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ABSTRACT

The workshop reported in this document focused on professional and patient smoking education. First, high priority clinical opportunities for smoking intervention were identified. Second, topically-oriented small groups met to plan activities in each of the following priority areas: (1) initiation of smoking cessation/maintaining non-smoking during and after pregnancy; (2) intervention with children at high risk; (3) health care providers and institutions as role models; (4) high risk patients; and (5) regular, periodic visits to a physician. The workshop discussions included extensive descriptions of the clinical opportunities, characteristics of the anti-smoking intervention, barriers that exist and how to overcome them, reaching and educating providers to intervene, and identification of organizations which could undertake efforts to increase effective provider intervention. These key themes are summarized: (1) identification of specific resources needed to assist health professionals to intervene more effectively with their smoking patients; (2) identification of key channels for professional and patient education and information dissemination; and (3) identification of the need for opportunities for networking/communication among organizations and individuals actively involved in smoking intervention. Appendices include the small groups' reports and a list of workshop participants. (ABL)

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NHLBI Smoking Education Program

Planning Workshop for Professional and Patient Education

January 29-30, 1985

Summary Report

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INTRODUCTION

The National Heart, Lung, and Blood Institute (NHLBI) is congressionally mandated to develop and foster information and educational activities designed to reduce preventable heart, lung and blood disease morbidity and mortality. As part of these health education efforts, the Institute is planning an NHLBI Smoking Education Program. The NHLBI Smoking Education Program is currently exploring educational opportunities in two major areas: 1) professional and patient education, and 2) worksite education. This report focuses on professional and patient education.

NHLBI is committed to providing its leadership and resources in working toward the development of an intensive effort to strengthen the role of health care providers in smoking intervention as one component of the program. It is also committed to working collaboratively and in a coordinated way with a large number of other federal, state, professional and voluntary organizations which are already involved in and experienced in the smoking field and/or in strengthening our health care system.

To this end, Polaris Research and Development--the contractor working with NHLBI staff--contacted a wide range of agencies and organizations currently involved in health education. Discussions were held with each agency or organization about their current involvement in anti-smoking health education efforts, current gaps in health education activities focusing on smoking, and their suggestions about how NHLBI could be more actively involved in anti-smoking health education.

A second aspect of NHLBI's collaborative planning effort was a planning workshop on professional and patient education held in Silver Spring, Maryland on January 29-30, 1985. NHLBI invited representatives from a number of interested organizations to participate in this two-day workshop. This report summarizes the activities of that workshop.

WORKSHOP PURPOSE AND AGENDA

The purpose of the workshop was to involve a group of knowledgeable professionals in a collaborative planning process to identify an overall program profile to strengthen the role of health care providers in smoking intervention and to identify candidate program elements and strategies for NHLBI health education efforts in coordination and collaboration with other organizations. Through the use of large group and small group discussions, the workshop focused on:

1) identifying clinical opportunities that exist in the practice of health care where smoking intervention techniques can be employed and which are not currently being fully capitalized on;
2) identifying the health care providers and program elements and strategies which need to be targeted in order to strengthen their ability to capitalize on these high priority clinical opportunities; and
3) identifying appropriate specific program elements and strategies for NHLBI to pursue, in coordination and collaboration with other organizations.

The following was the general agenda for the two-day planning session.

WORKSHOP AGENDA

Tuesday--January 29, 1985

9:00 - 10:15	Introductions, workshop purpose, background information
10:15 - 10:30	Break
10:30 - 12:00	Initial identification and discussion by the participants of clinical opportunities for smoking intervention which need to be strengthened
12:00 - 1:00	Lunch
1:00 - 2:45	Discussion and selection of "High Priority Clinical Opportunities"
2:45 - 3:00	Break
3:00 - 5:00	Break into small groups, each group assigned one of the high priority clinical opportunities. Each small group defines more specifically what program elements and strategies are needed to strengthen the smoking intervention abilities of health care professionals in relationship to the identified clinical opportunity.
5:00 - 7:00	Social Hour - Informal Discussion

Wednesday--January 30, 1985

9:00 - 10:30	Continue small group work
10:30 - 10:45	Break
10:45 - 2:45	Reports back from small groups, with identification of common themes and approaches (with break for lunch)
2:45 - 3:00	Break
3:00 - 4:00	General Discussion/Next Steps
4:00	Adjourn

IDENTIFICATION OF HIGH PRIORITY "CLINICAL OPPORTUNITIES" FOR SMOKING INTERVENTION

In order to focus the efforts of the workshop participants in identifying program elements and strategies for the NHLBI Smoking Education Program, the concept of identifying high priority "clinical opportunities" where smoking intervention techniques can be more effectively employed was utilized. **A "clinical opportunity" was defined as a clinical situation in which the provider can recognize or create a moment when patient receptivity to anti-smoking intervention is likely to be heightened (a "teachable moment").** Such a clinical opportunity, containing the potential teachable moments, may be characterized in terms of:

1) A type of patient as defined by health problem(s) and condition(s), plus

2) A diagnostic or treatment setting, and

3) Patient interaction with one or more health care providers.

In a brainstorming process involving all participants, a wide range of clinical opportunities was identified where smoking intervention techniques can be employed and which may not currently be fully capitalized on. The results of this brainstorming effort were recorded on flip charts and the typed "minutes" are included as Appendix A to this report.

The list of identified clinical opportunities was then reorganized by identifying categories of clinical opportunities and listing similar opportunities within the appropriate category. This organized/categorized list of clinical opportunities is attached as Appendix B.

Workshop participants were then asked to review the organized list and to select from it up to five clinical opportunities for more detailed analysis in small group planning sessions. All non-NHLBI workshop participants were invited to provide their suggestions through a weighted voting process.

The result of this selection process was the identification of the following five high priority clinical opportunities:

- Initiating smoking cessation/maintaining non-smoking during and after pregnancy for the health of both mother and baby
- Intervention with children at high risk because of smoking families and/or other risk factors
- Health care providers and institutions as role models and catalysts in creating healthy, smoke-free environments
- High-risk patients (patients experiencing conspicuous smoking-related disease conditions and/or at high risk for CHD due to presence of other risk factors)
- Regular, periodic visits to physicians

SMALL GROUP ANALYSIS OF HIGH PRIORITY CLINICAL OPPORTUNITIES

The workshop participants were then divided into five small working groups. Each group was assigned responsibility for analyzing in greater detail one of the identified high priority clinical opportunities. During approximately 3½ hours of small group work, each group analyzed its assigned clinical opportunity through a planning process which:

- Developed a more extensive description of the clinical opportunity, and identified which providers should be targeted in terms of this clinical opportunity
- Identified the general characteristics of the desired anti-smoking intervention by providers involved in this clinical opportunity
- Identified what barriers exist that keep providers from intervening more effectively (e.g., lack of information/knowledge, of motivation, of support, of intervention skills, of educational materials)
- Identified what providers need in order to become more effective intervenors (how can the barriers to intervention be overcome?)

- Identified how providers can best be given what they need to become more effective intervenors (how can the providers best be reached and educated?)
- Identified interested and involved federal, voluntary and professional associations which could collectively undertake efforts to increase effective provider intervention in this clinical opportunity

RESULTS OF SMALL GROUP WORKING SESSIONS

The planning activities of each of the five small groups was led by a facilitator and the group's work product was recorded on flip charts. The information recorded on flip charts from each small group is included as Appendix C to this report. The following discussion summarizes the results of each group's planning activities.

Small Group A: Maintain Non-Smoking/Initiate Cessation During and After Pregnancy for Health of Both Mother and Baby

Small Group A focused on pregnancy and the post-pregnancy period as an important clinical opportunity in which pregnant women can be urged to initiate smoking cessation or to maintain non-smoking behavior both for their own health and for that of their baby. Small Group A focused on anti-smoking education aimed at both the pregnant woman as well as her spouse/significant other and other members of the family. In defining the clinical opportunity with greater precision, group members agreed that anti-smoking education could take place in a number of settings (e.g., in OB/GYN, pediatrician, and family practice physician offices; in pre-natal, fertility, well-baby, and health department clinics; in hospitals; in homes for unwed mothers; in schools; and in community organizations offering pre-natal classes). Small group members also identified a range of health care providers who might intervene with smoking education messages in these settings. Potential intervenors included physicians (e.g., OB/GYN, pediatricians, family practice physicians), nurses (e.g., pre-natal, office/clinic, post-partum, pediatric, school nurses, and mid-wives), physician assistants, and other health care providers.

In considering intervention roles which health care providers could play in capitalizing on this clinical opportunity, the small group identified a number of possibilities:

- the health care provider could serve as a positive role model by demonstrating non-smoking behavior;
- health care providers could also ensure that they maintain a smoke-free environment in their office, clinic, or hospital;

- health care providers can obtain the patient's smoking history as part of the regular process of developing a patient's medical history;
- health care providers could provide direct anti-smoking counselling and follow-up;
- health care providers could provide both written and audiovisual materials on smoking cessation; and
- health care providers could make appropriate referrals to smoking cessation programs or establish in-house cessation programs.

Barriers to Intervention. Small group participants identified a number of barriers to intervention by health care providers. In terms of **health care providers serving as non-smoking role models,** the small group identified such barriers as "the self-righteous attitudes of non-smokers;" unclear perceptions about the importance of a health professional's example as an intervention message; and the fact that some professionals who smoke believe that they can still be effective as intervenors--the "do as I say, not as I do" attitude. In terms of **maintaining a smoke-free environment** in a medical office, clinic, or hospital, several barriers were identified: the lack of support by staff, administration and other patients; the fact that many health professionals lack the authority to make the setting smoke-free; unclear information regarding hiring policies for smokers and non-smokers; and a concern that a smoke-free environment may cause the loss of patients.

Barriers to **obtaining an accurate smoking history** from each patient included: a lack of clarity about who should be responsible for taking such a smoking history; the fact that questions about smoking behavior are not included on many medical history forms in current use; the perception of many health care professionals that taking a smoking history is either not a high priority or not my "duty;" a lack of clarity about what information should be gathered and what should be done with the information after the history is taken; and the fact that many health care providers do not have a consistent method of identifying smokers to facilitate follow-up after the smoker has been urged to quit. A number of barriers were also identified which constrain **smoking cessation counselling and follow-up** activities: the fact that many health care professionals do not give smoking intervention a high priority and that few possess effective counselling skills; that many professionals don't understand the amount of time or space required to facilitate smoking cessation counselling; that counselling activities may not be reimbursed; that cessation counselling follow-up may appear to be harassment and that

health care professionals who engage in it may lose patients; the shortage of nurses and a lack of clarity about whether a counselling role is legitimate for nurses; the reluctance of some physicians to collaborate with or delegate to other staff who might be involved in smoking cessation counselling; the time required to learn effective intervention skills; the frustration which health care professionals feel when they do not see quick results; the perception of some obstetricians that their "job is done at childbirth" or that it's "too late to quit in late pregnancy;" and the fact that the patient's spouse or "significant other" is often not included in counselling activities.

Barriers which constrain health professionals **distributing materials on smoking cessation** to their patients included: a lack of access, availability, and awareness about existing materials; a lack of materials at appropriate reading levels for some patients; a lack of "creative" media materials, especially those which are developed for a specific community and list local organizations and contact persons; the cost of materials; and the fact that some existing cessation materials provide conflicting information or advice. Barriers to health care professionals **referring their smoking patients to other providers** included: the fact that such referrals are not routine for most physicians or other health care professionals; a lack of knowledge about whether one method of smoking cessation is better than another; lack of information about available cessation programs within a community; the lack of follow-up by health care professionals after a referral is made; and the fear that some providers have that they may lose patients to other providers if they make smoking cessation referrals.

Methods of Addressing Barriers to Intervention. Small Group A also discussed ways in which the barriers to smoking intervention could be addressed. In order to encourage health professionals to serve as **non-smoking role models,** the group suggested that health professional organizations, nurse and medical specialty organizations should be urged to communicate with their members about the importance of being non-smoking role models. The small group also suggested that a national survey is needed to ascertain smoking levels among various health professionals. The group also suggested that media messages should be developed which target health professionals and address: 1) the importance of serving as a non-smoking role model for their patients; 2) the fact that health professionals who smoke typically lack credibility as sources of anti-smoking messages; and 3) the various components of non-smoking role model activity. In addressing the barriers to **developing smoke-free environments** in health clinics, offices, and hospitals, the small group suggested that health care professionals need "how to" information about creating a smoke-free environment. They suggested that professionals need materials,

models and technical assistance on planning a smoke-free environment and information which answers such specific questions as whether it is legal to refuse to hire smokers. The group also suggested that the establishment of smokeless environments in health clinics and offices could be enhanced through better networking among health care professionals who have established such policies. In specific, better communication and computer hook-ups should be established between health professionals who are interested in establishing a smoke-free environment and those who have done so successfully.

The group suggested that health care professionals could be assisted in **taking smoking histories** if they were provided with history forms which include questions on smoking behavior and smoking-related illness. The group also felt that there was a need for a clear "model" or "protocol" which set the standard for taking a smoking history. Group members felt that health professionals need additional materials to assist them in easily identifying smokers and suggested that health risk appraisal forms be built into the patient history taking process.

Methods of responding to barriers which constrain health professionals from becoming involved in **counselling their smoking patients** included efforts to modify the "role definition" of health professionals *vis a vis* smoking intervention. The group felt that major professional organizations (e.g., the American Medical Association (AMA), the American Nurses' Association (ANA), the National League for Nursing (NLN), the Nurses' Association of the American College of Obstetrics and Gynecology (NAACOG), and the American College of Obstetrics and Gynecology (ACOG), etc.) should be approached and urged to endorse the need for their members to become effective intervenors with smoking patients. In addition, the group suggested that undergraduate and graduate level medical education and continuing medical education courses should be developed to provide health professionals with the information and skills they need to become more effective intervenors. In specific, additional information should be provided on the effectiveness of different approaches to smoking cessation counselling.

To facilitate the **distribution of smoking cessation materials,** the group suggested the need for collaboration among voluntary organizations, hospitals, and federal, state and local agencies to produce, promote and disseminate coordinated materials on smoking cessation which are appropriate for use in specific areas and among specific target groups. The need for materials which target patients with lower reading levels was especially emphasized. The group also urged that better information clearinghouses be developed to coordinate the production and dissemination of smoking cessation materials. Several

specific ways of disseminating cessation materials were also identified, including distribution of anti-smoking information with home pregnancy tests and baby formula, and distribution by diaper services.

To stimulate better **referral of patients to smoking cessation** programs or to other health professionals involved in smoking counselling, the group suggested the development of directories of local cessation programs which are available within a given community and a description of the services offered. The group also suggested that health professionals need information about how to develop in-house cessation programs (especially in large clinics or hospitals).

Summary. In its summary, Small Group A emphasized the need to develop strategies to encourage health professionals to serve as effective role models of non-smoking behavior. The group suggested that the key was to develop "how to" information about the skills needed for health professionals to intervene effectively with their smoking patients and to refer them for additional counselling as required. The group also placed special emphasis on the need to develop communication and coordination mechanisms and networks among the voluntary and professional organizations in national, state and local agencies involved in promotion of smoking cessation.

Large Group Discussion of Small Group A Results. The results of Small Group A (and the other small groups) were reported back to a general session of workshop particpants on the second day of the workshop. The large group then discussed the results of Small Group A. Issues raised during the large group discussion focused on the special opportunities which health professionals have to intervene with women and other family members during and after pregnancy. The group noted that most women are especially receptive to information during pregnancy and are concerned about any behavior (e.g., smoking) which could cause harm to their baby. Several members of the large group suggested that physicians and other health professionals need to take advantage of this increased receptivity to present clear no-smoking "prescriptions". The group felt that physicians and other health professionals need to be made more aware of the importance of their "agenda setting" power with respect to pregnant women and mothers of infants. Other group members stressed the importance of providing health professionals with clear "how to" information about intervening with their smoking patients and referring them to cessation programs and additional counselling. Some group members suggested that a simple medical history form which included questions about smoking behavior would

provide physicians with a useful tool and that this could increase the likelihood of intervention with smoking patients.

Small Group B: Children at High Risk

Small Group B focused on children at high risk, including: 1) young children whose parents smoke (ages 5-7 especially), 2) children in age groups in which their peers are beginning to smoke, and 3) young people who experiment with smoking as a way of feeling grown up. The group also discussed targeting children with a disease exacerbated by smoking (e.g., asthma) or predisposing factors to cardiovascular disease. The group focused on smokeless tobacco as well as cigarettes and identified a special need among young people in lower socioeconomic levels since they are at higher risk of adopting smoking as a habit. The group felt that the approach in dealing with children at high risk should be both primary prevention ("don't start smoking") as well as smoking cessation.

Small Group B focused on two major problems which constrain intervention with children at high risk. The group acknowledged that one problem is that smoking-related medical problems typically don't manifest themselves in the young. For that reason, many intervention activities need to occur in the social arena rather than in the context of the provision of health care. Yet many health care providers do not have the opportunity to intervene in the social sphere of a young person's life where intervention may be the most effective. Another problem identified by the group is the fact that there is a basic lack of information available about effective intervention techniques for preventing smoking or encouraging smoking cessation among young people.

In discussing the types of providers which might be involved in intervening with children at high risk, the group suggested physicians (e.g., pediatricians, school physicians, primary care physicians), school nurses, specialists in pulmonary and heart disease and respiratory therapy, dentists and oral hygienists, nurse practitioners, physician assistants, and health educators.

The group identified a variety of methods of intervention, including asking about tobacco use during the taking of a medical history, and suggested that questions should be asked about the smoking behavior not only of the child but also of his or her peers and family. The group also identified the fact that tests that measure acute exposure to tobacco smoke (e.g., carbon monoxide measures using co-oximetry) could be used as an opportunity to provide smoking cessation information. In general, the group felt that all health

providers should adopt a policy of intervening and providing follow-up with their youthful patients and that intervention should: 1) raise the subject of tobacco use as an important health topic; 2) provide information about the health effects of smoking; and 3) reinforce or "prescribe" non-smoking behavior. The group also felt that intervention was necessary with the parents of babies and young children and that they needed information about the effects of parental smoking on the health of children and information about parents' power as smoking role models.

Barriers to Intervention. Small Group B identified a number of barriers which constrain intervention with children at high risk. Group members noted that there have been few studies of the effectiveness of cessation techniques for young people and that there are few effective cessation programs developed specifically for youth. In addition, no youth smoking prevention programs designed for physicians to use with young people are readily available. For this reason, members of the group suggested that physicians typically lack confidence about the effectiveness of intervening with children. In addition, many physicians lack counselling skills and are unaware of what other resources are available within the community. Small Group B also suggested that intervention is constrained by physicians' lack of time to become involved in intervention, by the cost of educational materials, and by the fact that smoking behavior is not typically the focus of forms used for taking medical histories. Other barriers which were identified included the fact that many physicians lack knowledge about how to be reimbursed for smoking counselling activities and the fact that they are often demoralized when smoking patients relapse.

The small group also noted that for many physicians smoking intervention is not a standard part of their "role definition." Group members suggested that major professional organizations and federal agencies have not given priority to the importance of the physician's agenda-setting power as a smoking intervenor. Few continuing medical education courses provide practical information and skill training to physicians on how to intervene more effectively.

Methods of Addressing Barriers to Intervention. Small Group B spent some time discussing the question "What do health care providers need in order to intervene?" The group identified the need for additional research on the effectiveness of different intervention techniques and materials. Group members felt that many physicians fail to intervene because they simply don't know "what works." If information on effective intervention techniques or cessation materials were disseminated in major professional journals, the group felt that physicians would be more likely to identify smoking

intervention as a high priority and actually intervene more often. The group also identified the need to provide information on smoking intervention in non-technical terms, to "demystify" the process of intervening with smoking patients. The group felt that additional efforts should be made to develop "model" prevention and cessation programs specifically designed for easy physician use. The need for a specific, brief, and simple intervention "protocol" was also identified. The group also identified the need to include smoking questions on medical history forms and to develop such simple materials as stickers for the charts of high risk patients to remind a physician to ask about their smoking behavior on an ongoing basis and provide follow-up counselling.

Small Group B focused on the need to involve major professional organizations in advocating smoking intervention as a regular part of the physician's job. The group suggested that such organizations as the American Academy of Pediatrics, the National Association of School Nurses, the American Academy of Family Physicians, the American School Health Association, and the American Dental Association should be urged to become advocates of: 1) non-smoking behavior by their members, and 2) the importance of intervention with smoking patients. The group also felt that these and other organizations could play an important role in the dissemination of a smoking intervention "protocol".

In discussing the roles of other organizations, the group identified the need for the National Institutes of Health and the Centers for Disease Control to become more actively involved in technology transfer regarding research on effective intervention techniques. The group felt that additional resource guides, summaries, and other materials on effective cessation programs should be developed by major federal agencies and voluntary associations. Such resource guides should provide specific "how to intervene" techniques and discuss factors which affect health care professionals' motivation to intervene with smoking patients. To motivate health care providers who interact with parents of young children, the group felt that they need information about the effects of parental smoking on the health of their children, the importance of parents as role models, and the importance of providing clear advice to quit smoking.

Small Group B also discussed the importance of urging intervention by school nurses in school districts where they are available, the need for continuing medical education courses on smoking intervention strategies, the development of community cessation

referral resource lists, and the importance of all professional organizations urging legislative solutions to the problem (e.g., raising the tax on cigarettes).

Large Group Discussion of of Small Group B Results. When the results of Small Group B were presented to all workshop participants, the discussion focused on a number of issues. Several members of the group pointed out that intervention with children at high risk must combine prevention and cessation approaches. Members of the group felt that physicians and other health professionals are typically unaware of effective prevention and cessation programs and often do not define smoking prevention or intervention with smoking patients as part of their traditional "role". Some participants noted that intervening with "high risk" children is difficult for health professionals since many of the most effective opportunities for intervention exist in settings in which the physician typically does not come in contact with children (e.g., schools, the home, community activities). The group suggested that smoking prevention programs designed for physician use need to be developed and broadly disseminated. The group also suggested that such non-physician intervenors as dentists, school nurses, and other youth-serving health professionals need to be involved in smoking intervention efforts.

Small Group C: Health Care Providers and Institutions as Role Models and Catalysts in Creating Healthy, Smoke-Free Environments

Small Group C focused on the need for individual health care providers to be personal exemplars of non-smoking behavior. The group emphasized the need for them to play an active role as "catalysts for change" in the smoking behaviors of their patients. In addition, Small Group C focused on the need to transform hospitals, physician offices, and other health care institutions into smoke-free environments.

The group suggested that hospitals can help develop healthy, smoke-free environments by limiting smoking to designated areas. They can better communicate the message that smoking is socially unacceptable and unhealthy. Hospitals can also develop in-house smoking cessation clinics. In some cases, these clinics might be provided in "exchange" for limits on smoking in the hospital. The group emphasized that the provision of smoking cessation clinics should be undertaken as part of the hospital's fulfilling its overall clinical responsibility, not just as a "public relations" activity.

The group also suggested that hospitals should ask about smoking behavior at the time of admission and provide patients with information about smoking cessation resources. The

group emphasized that physicians within a hospital must take seriously their role in affecting the hospital's policies regarding smoking and that all providers need to understand that they can effect change and transmit anti-smoking norms to each other and to patients.

Small Group C felt that it may be easier to develop smoke-free environments in physician offices than in hospitals since there is often a no-smoking policy in waiting rooms. The group suggested an intervention model which involved 1) no smoking in the physician office, 2) the provision of health education messages, 3) including questions about smoking behavior during the taking of medical histories, and 4) the provision of cessation counselling or referral for patients who smoke. The group suggested that environmental changes in physician offices should be designed to personalize the message for patients so that they "take the message home with them."

Barriers to Intervention. Small Group C identified a number of barriers to physicians and health institutions serving as no-smoking role models and in creating healthy, smoke-free environments. The group suggested that many physicians do not accept their role as exemplars of non-smoking behavior. The group noted that many physicians are not used to working together as "change agents" and that both physicians and hospital administration may worry about the loss of patients, employees, and revenues if they adopt no-smoking policies. In some cases, major policy-makers within a health care institution are themselves smokers and may be personally uncomfortable with efforts to develop smoke-free environments. Other problems which were identified by the small group included the fact that many physicians avoid intervening with smoking patients because they are demoralized by the frequency with which smokers relapse or fail to heed smoking cessation advice. The group suggested that smoking is often seen as a "behavioral" problem and therefore is not viewed by physicians as part of their responsibility as health care providers. In many cases, teachers involved in clinical programs don't focus on the need to intervene with smoking patients. For hospitals, the group identified such barriers as union opposition to non-smoking rules, the fact that terminally ill smoking patients are seen as inappropriate subjects for intervention, and difficulties in enforcing no-smoking or limited-smoking policies. The group also acknowledged that patients often wait for long periods of time in clinics and that a no-smoking policy can be seen as "punitive" in these circumstances. Finally, the group identified political barriers related to the power of the tobacco industry in various parts of the country.

Methods of Addressing Barriers to Intervention. Small Group C identified a number of strategies for addressing barriers to intervention among both individual health care providers and health care institutions. The group suggested that a simple intervention "protocol" together with examples of achievable results should be developed and distributed widely to physicians to break down the feeling that "there's nothing I can do about the problem." For example, the protocol could describe a variety of intervention approaches including: 1) brief (3-minute) counselling for all patients; 2) more intensive counselling (10-minute intervention repeated a second time) for all smoking patients; 3) referral to a self-help program; 4) referral to a cessation clinic or in-house extended counselling; and 5) prescription of nicotine gum together with 10 minutes of counselling. The group suggested that with this type of multifaceted intervention, a physician might achieve a 28% quit rate among his or her patients. By providing this type of "achievable" intervention advice, the group felt that individual physicians would be more likely to intervene with smoking patients and do so more effectively.

The group also suggested that both physicians and hospitals should be provided with data from studies which indicate that they are not likely to lose patients, employees or revenues as a result of limiting or banning smoking. The group felt that union oposition might be overcome by developing trade-offs in which non-smoking rules were offset by increased health packages for union members. Other suggestions included allowing physicians to "prescribe" (allow) smoking for terminally ill patients, offering alternatives such as candy or gum to patients who might otherwise smoke during long clinic waits, and urging clinical teachers to include smoking intervention as one of the issues they discuss with undergraduate and post-graduate health professions students.

Communication Channels. The group suggested that physicians and health care institutions will be more likely to serve as exemplars of non-smoking behavior and act as catalysts for change in developing healthy smoke-free environments if major professional organizations can be motivated to underline the importance of communicating non-smoking messages as part of the standard practice of medicine. The group suggested that major professional associations should be urged to take the lead in developing non-smoking policies for their members and recommend those policies to organizations like the American Hospital Association. It suggested that the Surgeon General's call for a smokeless society by the year 2000 should be used in advocating the development of smoke-free environments in veterans and military hospitals operated by the federal government. The group underlined the importance of placing articles on the development of smoke-free environments in major medical journals and suggested that future Surgeon

General's Reports should continue to address the health care professional's role in smoking cessation, perhaps including a chapter on hospital smoking policies, and the roles of physicians, physician assistants, nurses, and other health care providers. It also suggested that better information about reimbursement for cessation counselling should be provided to both individual health professionals and health institutions.

The importance of developing peer support for smoking intervention and the establishment of non-smoking policies was emphasized by the group. It urged a grassroots approach involving county medical societies as well as "top down" dissemination approaches. It suggested that continuing medical education courses need to be developed which publicize a smoking intervention "protocol." It felt that training programs which provide basic "how to" information need to be provided to physicians, nurses, physician assistants, and other health care providers. The group felt that smoking intervention training should emphasize the development of actual intervention skills. It identified the need for role playing and the use of interactive videotapes as a way to help physicians and other health care providers gain the interventions skills they need.

The group also discussed the possibility of influencing the national medical boards to include questions about smoking cessation to reinforce the importance of physician intervention with smoking patients. Among other ideas generated by the group was the possibility of using detail men from drug companies who are involved in the distribution of nicotine chewing gum to disseminate information about cessation intervention and the development of smoke-free health care environments; the use of the Great American Smoke-Out Day as an event to promote smoke-free areas in hospitals; the development of a central respository of professional and patient education smoking materials; and the increased use of lab tests to help demonstrate the effects of smoking where they are not otherwise conspicuous.

Large Group Discussion of Small Group C Results. In the discussion of the results of Small Group C, the large group made a number of additional points. The group discussed the difficulty of convincing hospitals and other health care institutions to develop or expand no-smoking policies. The group noted that union opposition to such policies is often strong and that hospital administrators are not clear about the types of policies which have proven effective in other institutions. In addition, several participants suggested that physicians often do not see themselves as "change agents" within hospitals and have not traditionally been involved in the development of hospital policies regarding smoking.

The group debates whether it would be legal and/or feasible for hospitals to develop hiring policies which give preference to non-smoking applicants. The group also pointed out that many nurses smoke on the job and that this presents a negative role model to patients. Some large group members suggested that on-the-job smoking by nurses is related to the stress of their job and that more needs to be done with nurses' professional associations to address this problem.

Several large group participants stressed the importance of including specific recommendations about the role of health professionals in intervening with smoking patients in future editions of the Surgeon General's report. The group also debated the feasibility of including questions on smoking intervention as part of the National Medical Boards. Some participants felt that this would communicate a clear message about the importance of health professionals intervening with smoking patients, whereas others felt that it was desirable but infeasible.

Small Group D: High Risk Patients

Small Group D focused on the need to capitalize on a clinical opportunity involving high risk patients and their families. The group felt that patients with certain types of health problems are likely to be highly receptive to a smoking cessation message. Included in this group are patients who have had a heart attack, a by-pass operation, who have some other form of cardiovascular disease, chronic obstructive pulmonary disease patients, patients who have had a cerebral vascular accident, a transient ischemic attack, cancer of the head, neck or lung, patients who have had repeated upper respiratory infections, hypertensive patients, those with hypercholesterolemia, diabetics, patients suffering peripheral vascular disease, etc. The group also emphasized the importance of intervening with families of patients who have smoking-related diseases.

The group identified a wide range of health professionals who could intervene with smoking patients who have a major smoking-related illness. In the case of patients who have recently had a heart attack and are in a coronary care unit, the group identified cardiologists, the primary care physician, and the coronary care unit nurse as primary intervenors. Secondary intervenors included the cardiovascular surgeon, respiratory therapist, hospital health educators, clergy, and staff of the hospital cessation program if one is available. After heart attack victims leave the coronary care unit but are still in the hospital, the group suggested that ward nurses and primary care physicians should be primary smoking cessation intervenors while the cardiologist, the cardiac rehabilitation staff and staff of the hospital cessation program could serve as secondary intervenors.

After patients who have suffered heart attacks leave the hospital, intervention and follow-up should be the primary responsibility of the primary care physician, the office nurse, and hospital or community cessation programs.

In the case of patients suffering from chronic obstructive pulmonary disease, pulmonologists, pulmonary technicians, and respiratory therapists were identified as key smoking cessation intervenors. In the case of patients having cancer, oncologists, dentists, oncology nurses, and radiation therapists were identified as having a significant opportunity to intervene with smoking patients.

A number of intervention strategies were identified by Small Group D. The group emphasized the importance of relating smoking to a specific individual disease as a way to "personalize" smoking as a risk that affects a specific individual. The group felt that health professionals need to relate smoking to the level of risk which the patient faces of dying or worsening his or her existing health condition. It suggested the importance of "quantifying" both the level of risk involved in smoking and the benefits of quitting. The group emphasized that all health care providers need to give clear "stop smoking" messages and help patients identify and utilize smoking cessation programs. It emphasized the importance of providing patients with both smoking cessation educational materials and skills during both the cessation and maintenance period. Providing assistance during the maintenance phase was stressed, together with the need for health care providers to provide follow-up--to repeat intervention messages for patients who continue to smoke or who relapse.

For families of patients with smoking-related diseases, the group identified the need for health care providers to do a risk factor appraisal for other family members. The group acknowledged that outreach to families of high risk patients is not a common physician activity and discussed whether hospitals should be the primary vehicle for outreach to family members. The group identified the need for a family screening protocol for children and siblings of CHD patients.

Barriers to Intervention. Small Group D identified a number of **awareness** barriers which constrain physicians and other health care providers from intervening with high risk patients and members of their families. The group noted that many health professionals are not convinced that intervention will "work". They lack information on successful intervention methods and are unclear about the type of cessation programs which work and for which type of patients they are appropriate. The members of the group felt that

most physicians underestimate their "agenda-setting" power for their patients and are not aware of how important an anti-smoking message delivered by a physician can be. They also suggested that physicians often are not aware that 4 to 5 relapses are common among patients who try to quit. For that reason, physicians often become demoralized when patients relapse and this may undercut their willingness to intervene in the future. The group also suggested that many nurses don't fully acknowledge the health risks of smoking and that the high rate of smoking among nurses makes them less likely to intervene effectively with smoking patients. The group identified the need for nurses to model non-smoking behavior but acknowledged that job-related stress and the fear of weight gain during smoking cessation limits the number of nurses that quit smoking themselves.

The group felt that a number of **motivational** barriers also constrained intervention efforts. Group members suggested that the standard role definition for physicians does not include smoking intervention. The group suggested that there are few influential role models who are currently reinforcing the notion that smoking intervention is part of the "standard" practice of medicine. The group felt that physicians are traditionally more interested in disease than in prevention and that smoking is not currently considered a "disease" by many. Some group members felt that preventive medicine is still a "second-class citizen" and that smoking intervention is not viewed as a central role of "real doctors". The group also cited motivational barriers such as the fear of failure and the lack of peer support when a patient relapses, fear that intervention will cause a physician to lose patients, and the fact that intervention and counselling may not be compensated. With respect to nurses, the group suggested that they are not perceived by other providers and often by themselves as independent practitioners and that they may thus lack "permission" to intervene with smoking patients.

In terms of **intervention skills,** the group suggested that health professionals lack information about what intervention techniques actually work and "how much" they work. The group felt that most health professionals do not have strong counselling and intervention skills and that they are not comfortable acting as intervenors and smoking cessation counselors.

Methods of Addressing Barriers to Intervention. Small Group D emphasized the need to increase the degree to which health professionals include intervention with smoking patients as part of their standard "role definition." The group felt that role models and "educational influentials" who shape the attitudes of health professionals need to be more actively involved in defining smoking intervention as an important activity that is an

essential part of the overall provision of health care. The group suggested that major professional associations should be urged to better educate their members about the importance of smoking as a health risk factor and the need for health professionals to intervene with patients who smoke.

The group also suggested that physicians and other health professionals need more "how to" intervention skills and that undergraduate and graduate level curriculum and continuing medical education courses need to be developed which not only motivate health professionals to intervene with smoking patients but provide them with the skills to do so. Different materials need to be developed for different physician specialties, for nurses, physician assistants, and other health care professionals. In addition, articles on the importance of intervention and specific intervention techniques need to be incorporated in articles in professional journals.

Large Group Discussion of Small Group D Results. During a discussion of the results of Small Group D, a number of points were made. The group discussed the importance of incorporating smoking intervention as part of physicians' and other health professionals' definition of "the traditional practice of medicine." Several participants suggested that the lack of intervention with smoking patients is a motivational barrier that needs to be addressed by a wide range of health professional organizations and federal agencies. The group discussed the importance of developing health professional role models who speak openly and consistently about the need for physicians to intervene with smoking patients. The group also underlined the importance of expanding existing continuing medical education courses to include skill-building sessions on smoking intervention. Some participants suggested that physicians need intervention "skills" as much if not more as information about intervention techniques. The group also underlined the need for "peer support" of physicians who are attempting to intervene with smoking patients. It noted that patient relapses are common and that physicians need to be helped to develop "realistic" expectations about smoking cessation efforts.

Small Group E: Regular, Periodic Visits to a Physician

Small Group E focused on the regular, periodic physician visit as a clinical opportunity for smoking intervention. It defined the clinical opportunity to include not only the taking of a medical history and a physical examination but lab tests, immunization, and such specialty exams as a birth control exam, complete physical, female pap smear exam, and physical exams conducted as part of a pre-employment screening, a sports exam, and

health and life insurance exams. It also suggested that intervention could take place in senior citizen residential communities and in social service programs.

In terms of the type of health care providers who can intervene in these settings, the group identified family practitioners, internists, pediatricians, OB/GYN physicians, nurses, nurse practitioners, school nurses, health educators, preventive medicine specialists, psychotherapists, physician assistants, medics, osteopathic physicians, respiratory therapists, visiting nurses or clinic outreach program staff, emergency room staff, dentists, and staff of stress management programs.

In discussing desirable types of intervention, the group identified the need to identify smoking patients and take complete medical histories which include information about smoking behavior. The information gathered should include how much the patient smokes, the presence or absence of a family pattern of smoking, whether and how many times the patient has tried to quit smoking, patient attitudes regarding smoking cessation, and such additional information as the patient's exercise history. The group also suggested that intervention can include the use of pulmonary function tests. The group also discussed the need for chest X-rays for smoking patients and the gathering of information about other risk factors, including occupation, blood pressure, cholesterol, weight, heart disease, lung disease, and cancer. Members of the group stressed the importance of the physician's identifying the psychosocial factors which motivate each patient to smoke and assessing the patient's knowledge, attitudes and beliefs about smoking. They suggested that the physician or other health professional intervening with the patient should provide clear alternatives to smoking behavior and "prescribe" smoking cessation in cases in which smoking is clearly tied to the patient's health condition. The importance of outreach to low-income patients who smoke was also stressed.

Barriers to Intervention. Small Group E identified a basic lack of information about the effectiveness of smoking cessation intervention as a major barrier to intervention activities. They cited the fact that many health care providers are not knowledgeable about intervention techniques and about the types of intervention which are effective. The group also suggested that many physicians feel that they lack the time to become involved in intervention and that current patient assessment instruments do not gather adequate information about smoking behavior. Other barriers identified by the group included the lack of feedback to the physician about whether intervention efforts are working and the fact that patient resistance to smoking intervention may undermine the motivation of health professionals.

Methods of Addressing Barriers to Intervention. Small Group E suggested that intervention could be facilitated if physicians were provided with a basic "package" on intervention which defined: 1) the type of information which needs to be gathered from the patient; 2) the types of tests which are useful in identifying smoking-related problems; 3) a clear definition of the physician's role in smoking intervention; 4) a description of other health professionals' roles in intervention; 5) information on smoking cessation referrals; and 6) information on the development of a follow-up system after a referral. The group also felt that physicians and other health professionals need better training on patient interviewing skills and intervention techniques. Providers need to know what types of intervention techniques have proven most effective and information about the different types of cessation programs which are available.

The need for continuing medical education on smoking intervention techniques was stressed together with the need to increase acceptance of the view that intervention with smoking patients is a central part of the practice of medicine. The group felt that physicians and other health professionals need special help in developing strategies for intervening with smoking patients who are resistant to intervention. Other strategies for addressing barriers to intervention included increasing the degree to which third-party reimbursement covers smoking cessation counselling, the inclusion of smoking cessation information questions on medical board exams, and developing self-help intervention audiovisual materials for use in physician offices, clinics, and emergency rooms.

Communication Channels. Small Group E identified a number of dissemination strategies and groups that should be involved in communicating smoking intervention messages. In terms of medical education, the group identified the need for more written materials, inclusion of information on intervention in medical textbooks, audiovisual materials, and the inclusion of intervention information in training courses. The group urged that smoking intervention information be disseminated through professional organizations, through self-help groups developed for cancer and heart disease patients, etc., through government task force recommendations, through hospitals and hospital satellite networks, and through public education. Key organizations that should be involved included a variety of agencies of the federal government, major physician, nursing, and other health care provider associations, the American Hospital Association, health maintenance organizations, military organizations, organizations representing the elderly, media organizations, the airlines, and a wide range of voluntary organizations.

Large Group Discussion of Small Group E Results. Several large group participants suggested that physicians need simple systems of identifying and following up with their patients who smoke. The group discussed a number of tools which would facilitate physician intervention with smoking patients, including improved medical history forms, methods of "flagging" smoking patients' office files, the use of posters and other graphic materials in the physician's office, and follow-up procedures for contacting patients who have been advised to stop smoking. The group underlined the need for a simple "protocol" which describes the basic steps in smoking intervention and cessation counselling. It also suggested that materials should be developed for use by nurses working in physician offices since they can also be important intervenors with smoking patients.

SUMMARY OF KEY THEMES

In addition to the extensive information generated by each small group in analyzing its specific assigned clinical opportunity, an important outcome of the workshop included the identification of some key themes which recurred in the analysis of high priority clinical opportunities. Key themes included:

- **The importance of health care providers and health care institutions as role models and catalysts for change in patients' smoking behavior.** This theme was identified in most of the small groups. It was suggested that increased emphasis and encouragement from professional associations would be an effective approach to raising the awareness of and participation of health professionals in this area. A related theme that was frequently discussed was the importance of assuring that health care facilities are smoke-free environments and, again, the important role that can be played by health professionals in promoting this goal. The definition of smoke-free environments that was developed was one which went beyond the concept of "no smoking allowed." It included viewing smoke-free environments as intervention opportunities themselves, with health education materials being made available, a commitment to asking every patient about smoking, and a commitment to advising and counseling or referring every smoking patient for personalized intervention.

- **Specific resources needed to assist health professionals to intervene more effectively with their smoking patients.** A number of similar suggestions for specific kinds of resources to assist health care providers in intervening with their smoking patients were identified in the small groups. These included:

  -- **A short, simple, specific intervention protocol.** Such a protocol would describe a series of intervention steps which the physician or other health professional might undertake with a smoking patient. It would include a brief discussion of what would be involved in each step and the expected success rate. If step 1 were not successful, then the protocol would guide the professional in step 2 to using an alternative intervention strategy, and so forth. The protocol could also include guidance in terms of personalizing both the risk to the patient of continued smoking and the potential benefit of smoking cessation.

-- **An enhanced process for taking smoking histories.** It was suggested that physicians need to be encouraged and assisted to take more comprehensive smoking histories for their patients. Not only would such a history provide more comprehensive information needed to allow more effective intervention, but the actual taking of the history can be part of the intervention process. Suggestions were developed in a number of the small groups concerning the need for a "smoking history form" which would include the gathering of information about the patient's own smoking habits (how much, patterns, previous attempts to quit, attitudes toward quitting), about family smoking patterns, and about other CHD risk factors (e.g., hypertension, elevated blood cholesterol). A process for "flagging" smoking patients so as to facilitate follow-up counseling was also suggested.

-- **Development of skills in terms of known effective intervention methods.** A number of the small groups noted that most health care providers do not know what intervention techniques are effective and/or do not feel skilled or confident in implementing them. It was suggested that skill-building sessions need to be endorsed/sponsored by professional associations and/or recognized federal agencies and incorporated into continuing medical education courses. It was suggested in a number of groups that such training in interviewing and counseling techniques would be most acceptable to physicians if it were incorporated as part of other regular CME programs and that such training programs need to be geared specifically to MDs, to physicians assistants or to nurses.

-- **Information on smoking cessation programs and clinics to which patients might be referred.** Several groups suggested that health professionals do not now know about the availability of smoking cessation programs and/or do not know how to identify and suggest quality programs to their patients.

- **Key actors in/channels for professional and patient education and information dissemination.** Participants in all the small groups indicated that the professional associations of the various health care disciplines and specialties are among the most effective channels for reaching health professionals. In addition, major federal organizations such as the National Cancer Institute and the National Heart, Lung and Blood Institute are respected by health professionals, and materials distributed by them or programs endorsed by them are likely to at least attract the professionals' attention.

Other potential sources for mass distribution of information which were identified included the "detail men" representing the pharmaceutical companies who might serve as a channel for distribution of a smoking intervention protocol and/or a smoking history form. Suggestions for reaching pregnant women and mothers with smoking cessation information included seeking to incorporate information in home pregnancy tests, in disposable diaper boxes, and in the packaging of formula.

In terms of raising the overall awareness and willingness of professionals to intervene with smoking patients, a number of small groups identified the importance of local professional leaders or "educational influentials." The role of county medical societies and local branches of professional associations in encouraging and assisting key members to speak out about their positive attitudes and practices towards intervening with smoking patients was viewed as critical.

- **The need for opportunities for networking/communication among organizations and individuals actively involved in smoking intervention.** Increased opportunities for communication and networking among individuals and organizations was seen as a need for several reasons. First, there is a need for increased opportunities to share experiences about intervention models that are proving to be effective. Second, given the difficult nature of smoking intervention, there is a need for increased opportunities for peer support and acknowledgement of the successes that are achieved. Some specific suggestions in this area included the concept of a central repository for professional/patient education smoking materials, continued support of Smoking and Health Reporter, and establishment of an "association of smoking cessation educators."

APPENDIX A

BRAINSTORM OF CLINICAL OPPORTUNITIES

NHLBI SMOKING EDUCATION PROGRAM:
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BRAINSTORM OF CLINICAL OPPORTUNITIES

A "CLINICAL OPPORTUNITY" is a clinical situation in which the provider can recognize or create a moment when patient receptivity to anti-smoking intervention is likely to be heightened (a "teachable moment"). Such a clinical opportunity, containing the potential for teachable moments, may be characterized in terms of:

1. A type of patient as defined by health problem and condition, plus
2. A diagnostic or treatment setting, and
3. Patient interaction with one or more health care providers.

(Note: not all of the following may satisfy the above definition of a "clinical opportunity." We have included them, however, because they were suggested at the workshop and many of them are useful and interesting ideas even if they are not, strictly speaking, "clinical opportunities.")

Clinical Opportunities

- Patient with MI
- Young patient with MI
  -- family at risk
  -- children should be educated about smoking, HBP, high blood cholesterol
  -- spouse
  -- siblings of MI patient
- High-risk groups of young people--from smoking families
  -- pediatrician intervention
- Patients with upper respiratory disease
  -- private MD
  -- worksite MD
- Issue of smokeless tobacco--in schools
- patient with MI
  -- children
  -- siblings
- Annual dental visit
- OB/GYN annual visit
- OB/GYN pregnancy visit

- Pulmonary function tests--relate to smoking message
  -- equipment to demonstrate their smoking-related problem which otherwise wasn't conspicuous

- Schools
  -- RN-student
  -- teacher-student
  -- MD--sports--physicals and student exams
  -- coach-student

- Smoking--athletics
  -- team captains as interveners

- Get school coaches to quit--be exemplary

- Families of all patients with heart and pulmonary problems
  -- no smoking in asthmatic's house

- Health care worker in health care setting--person to carry anti-smoking message
  -- grand rounds
  -- janitors, housekeepers have most contact with patients
  -- test-givers

- Team approach--in hospital and beyond
  -- identify team with respective intervention roles

- Emphysema patients don't know they are in trouble until down to 20% of lung capacity
  -- intervene during earlier testing

- Physical exams for Boy Scouts and Girl Scouts

- Health fairs

- Any site where health risk assessment is conducted

- Child care preparation classes (e.g., parenting classes)

- Well baby clinics
  -- "stay quit" message

- Don't write off RNs--interested in getting involved

- Pharmacists--lots of interaction with patients
  -- no cigarette sales in pharmacy
  -- Nicorette

- Worksite
  -- nurse and MD intervention with workers
    - routine contacts
    - health risk appraisals

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- Every health care facility should be smoke-free (as possible)
  -- environment as role model
  -- providers as role models
- Worksite--pre-employment and annual physicals--providers should encourage and assist smokers in cessation (not just pressure from non-smokers)
- Institutional settings, jails (problem: nursing home residents rewarded by nurses, PAs with cigarettes)
- Health clubs
  -- contact, interaction re. smoking
  -- physical therapists, physical educators
- Media use in MD offices and waiting rooms
  -- inpatient rooms in hospital
- Dental clinics
- Sex therapists; sex clinics
  -- smoking/sex problem relationships
- Health Maintenance Organizations
  -- cost control issue
  -- respiratory disease = $
- Family planning clinics
  -- birth control pills and smoking
- Patient history-taking
- Asking during any patient care visit by a smoker--provide some intervention counseling
- Counsel when any clinical manifestation
- Protocols needed for intervention
  -- how to intervene oneself
  -- or how to refer to another provider (intervener) for "treatment" of smoking
- Health insurance salespeople
  -- role models
  -- MDs should alert them
  -- also policy-makers
- Health promotion at worksite and safety education
- Other costs of smoking besides health costs
  -- residence fires
  -- firefighters as interveners

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- Informal channels of communication
  -- MD is a catalyst to triggering these in any institution
  -- spokesperson for creating non-smoking norms
  -- help them exercise this catalyst role
- Well baby/prenatal visits/Women, Infants and Children (WIC) program--relate to lower socioeconomic status groups with high smoking rates
  -- risks to mother and to baby from passive smoking
- Employment officers in health care institutions
  -- can discriminate (?) in hiring on basis of smoking--ruling by civil rights commission?
  -- advertise jobs as "non-smoker preferred"
- Substance abuse programs
  -- many of these abusers also smoke
- Cancer clinics
- Ask every patient if he or she smokes
- MDs and their office workers should not smoke as role models
  -- MDs should have non-smoking environment in their offices
  -- hire only non-smokers
  -- non-smoking messages should be posted prominently
- Self-help organizations--people with cancer, e.g., Candlelighters
- Sports medicine clinics
  -- often deal with younger population
- Health clubs
- During pre-operative teaching for all surgeries and in surgical centers
  -- abdominal
  -- chest
- "How to intervene" modules in medical and nursing schools
- Emergency rooms which serve as "family doctor" for many poor people
- Volunteer organizations' free clinics--need to know where to refer people who smoke
- Centers for Independent Living
- Low-income population contact points
  -- mom-and-pop stores
  -- pastors
  -- other storekeepers

- Unions
  -- smoking policies become negotiated item of contracts
  -- medical benefits--including annual exams, counseling as a "benefit"
- VA physicians and Armed Services physicians
- Day care workers--physicals, create healthy environment, talk to families of kids
- Personal patient assessment at physical exam--have cardiovascular and pulmonary risk assessed--personalize risk
  -- synergy of risk factors
  -- "if you stop smoking, you reduce your risk of CHD event by "x"% =
  personal message of a) vulnerability and b) risk reduction related to modification =
  scare + good news associated with modification of behavior
- Message about smoking on cards for next appointment
- Military Basic Training (Department of Defense paper) and annual physical fitness tests (officers as role models)
- Parent-teacher meetings
- Weight control professionals, programs
- College and university health service programs
- Pediatricians help mothers maintain non-smoking behavior started during pregnancy
- Nurse specialists outside of cardiopulmonary areas, e.g.:
  -- diabetes
  -- renal
  -- occupational
  -- orthopedic
- School nurses seeing repetitively sick children
  -- inquire about smoking in home
  -- talk to parents
- Different things work with different patients
  -- cardiologists, pulmonologists, etc., need to write, talk, teach about smoking cessation
- MDs get information at big meetings from their peers
  -- not on smoking intervention
- MDs as trainers--catalysts for change
- Specialists may be most motivated and effective catalysts, organizers, teachers
  -- and may influence general practice people

- postmortems
  -- death certificates
  -- cause of death
  -- raise consciousness of MDs

- Soup kitchens, shelters, drop-in centers, health centers

- Geriatric group--who have smoking-related illnesses
  -- clinics, nutrition centers, nursing homes

APPENDIX B

CLINICAL OPPORTUNITIES: ORGANIZED/CATEGORIZED (PRELIMINARY)

NHLBI SMOKING EDUCATION PROGRAM:
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CLINICAL OPPORTUNITIES: ORGANIZED/CATEGORIZED (PRELIMINARY)

I. Regular or Routine Physician Visits/Physicals

A. Physical exams for Boy Scouts and Girl scouts

B. Employment, work-required, annual physicals, visits without conspicuous smoking disease condition (personal patient assessment of vulnerability and modification of impacts)

C. Dentists

D. OB/GYN

II. At-Risk Patients and Families

A. Families of patients with smoking-related disease (e.g., CHD/MI, emphysema)
-- counsel family members for their prevention/cessation

B. At-risk patients with conspicuous smoking disease condition--at time of:
-- cardio/pulmonary testing
-- repeated cardiovascular or respiratory disease experienced
-- pre-operative training
-- hospitalization

C. Post-related-illness patients

III. Military

A. VA and Armed Forces providers

IV. Women as Mothers

A. Family planning clinics (smoking and birth control pills)

B. Maintain smoking cessation/no smoking after pregnancy/no passive smoke with baby
-- pediatricians
-- well baby clinics
-- parenting classes
-- WIC

V. Children/Schools

A. MDs and nurses doing physical exams, seeing sick children in school

B. Coaches, teachers counseling no smoking and as role models

VI. Children/Pediatricians

A. Intervene with children at high risk because of smoking families and/or other risk factors

VII. Health Care Providers and Health Care Institutions As Non-Smoking Role Models and Catalysts for Smoke-Free Environments

VIII. Other Settings

A. Other substance abuse programs

B. Health clubs, sports medicine clinics

C. Health fairs

D. Centers for independent living

E. Self-help groups for cancer patients

F. Cancer clinics

G. Worksite programs

IX. Poor and Low Socio-Economic Status Populations

A. Poor--soup kitchens, shelters, free clinics

B. Low SES--emergency rooms, free/low-cost clinics

FIVE HIGH-PRIORITY CLINICAL OPPORTUNITIES SELECTED FOR ADDITIONAL ANALYSIS IN SMALL GROUPS

A. Maintain non-smoking/initiate cessation during and after pregnancy for health of both mother and baby

B. Children at high risk

C. Health care providers and institutions as role models and catalysts in creating healthy, smoke-free environments

D. High-risk patients

E. Regular, periodic visits to physician

APPENDIX C

REPORTS FROM SMALL GROUPS

NHLBI SMOKING EDUCATION PROGRAM:
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SMALL GROUP A

CLINICAL OPPORTUNITY: Maintain Non-Smoking/Initiate Cessation During and After Pregnancy for Health of Both Mother and Baby

Consider:
- Mother
- Baby
- Spouse (significant other)
- Family

Physicians	Nurses	Others
OB/GYN	Prenatal	Physician Assistants
Pediatrician	Office/clinic	Medics
Family practice physician	Post-partum	
	Pediatric nurse	
	School nurse	
	Midwife	

Settings

- Office (OB/GYN, pediatrician, family practice)
- Clinic (prenatal, fertility, well-baby, health dept.)
- Hospital
- Homes for unwed mothers
- Schools
- Community organizations offering prenatal classes

Health Care Provider Roles

1. Be a role model by not smoking
2. Maintain a smoke-free environment (office, clinic, hospital)
3. Obtain smoking history
4. Give direct counseling and follow-up
5. Provide materials (written, audiovisual) on smoking cessation
6. Make appropriate referrals or provide in-house cessation program

Barriers to Intervention

1. Health Care Provider as Role Model
   - self-righteous attitudes of non-smokers
   - unclear perception of what is a role model
   - unclear perception of importance of professional's example
   - professional who smokes may believe he/she is believable as an intervener--"Do as I say, not as I do!"

2. Maintaining Smoke-Free Environment
   - No support by:
     -- Staff
     -- Administration
     -- Other patients
   - Lack of authority to make setting smoke-free
   - Unclear information regarding hiring policies for smokers/non-smokers
   - Worry about possible loss of patients

3. Obtaining Smoking History
   - Who's responsible for getting it?
   - Not on the forms now used
   - Not my "duty"
   - Not a high priority
   - What to do with information
   - What facts to gather?
   - No consistent method of flagging smokers to facilitate follow-up

4. Counseling and Follow-Up
   - Don't know effective counseling skills
   - Not always high priority
   - Need to provide adequate time and space for counseling
   - Costs involved may not be reimbursed
   - Follow-up may seem like harassment--fear of losing patients
   - Shortage of nurses
   - Unsure if counseling role is legitimate (for nurses)
   - MD reluctance to collaborate with/delegate to other staff
   - Need time to learn intervention skills

- Nurses and other staff don't take initiative with smokers
- Frustration with lack of quick results
- OB:
  -- "Job is done at childbirth"
  -- "Too late to quit in late pregnancy"
- Spouse or significant other not included in counseling

5. Materials to Supplement (audiovisual, written)
   - Lack of access, availability, awareness
   - Lack of materials at appropriate reading levels
   - Lack of "creative" media and materials: specific to community with contact person identified
   - Lack/cost of materials and supplies
   - Presence of conflicting information in materials

6. Appropriate Referral for Care (other health care organizations or providers)
   - Not done routinely
   - Poor knowledge of where and to whom to refer (is one method better than another)
   - Lack program information--no directory
   - Lack of follow-up
   - Threat of losing patients to other providers

Solutions

1. Role Model
   - Support from health professional organizations, nurse and medical specialty organizations to underscore need to be role model
     -- American Nurses' Association (ANA)
     -- American Medical Association (AMA)
     -- American College of Obstetrics and Gynecology (ACOG)
     -- Nurses Association of the American College of Obstetrics and Gynecology (NAACOG)
   - National survey to ascertain smoking levels among health professionals--need data
     -- Smoking cessation for health professionals
   - Media messages about power of example
     -- importance of role model
     -- lack of credibility of smokers
     -- components of role model activity

2. Smoke-Free Environment
   - Experts, materials, models on how to create smoke-free environment
   - Enhance communication through computer/communication link-ups
   - Hiring policy clarification: can refuse to hire smoker?

3. Smoking History
   - Clear-cut models (information) on what is important in smoking history
   - Materials for easy identification of smokers
   - Incorporate HRAs into assessment
   - Change current history forms

4. Counseling
   - Endorsement by spec. org (national, state, local)
     -- AMA
     -- ANA
     -- NLN
     -- NAACOG
     -- ACOG
   - Education
     -- undergraduate
     -- graduate
     -- CMEs, CE courses
   - Counseling models that are effective

5. Materials
   - Collaboration (voluntaries, hospitals, feds, state, local) to promote, disseminate, produce coordinated materials appropriate to locale and target group
     -- including lower reading levels
   - Maximizing network of clearinghouses which coordinate all types of groups producing materials
     -- where possible, evaluation should accompany material (especially reading level)
   - Information included in literature distributed through:
     -- home pregnancy tests
     -- baby diapers, formula, furniture, etc.

6. Referral
   - Directories of programs in community
     -- description of programs and services offered
   - Develop in-house capability (cessation programs)

Identify Key Groups (how we can work together)

- Enhance communication among those involved
- Establish coordinating mechanism for national organizations involved
- Establish coordinated effort among feds

Summary

Important Points:

- Health professional as role model
- Provide tools/skills needed for health professionals to intervene and to refer patients appropriately
- Need network and communication among all the key actors

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SMALL GROUP B

CLINICAL OPPORTUNITY: Children at High Risk

Definition of Clinical Opportunity

Children at high risk

- 17 and under generally (usually treated by pediatrician)
  - -- parents who smoke (ages 5-7 especially)
  - -- peers smoke (older peers affect younger--ages 12-14 especially; same-age peers affect ages 24 and up)
  - -- need to feel grown up (especially age 12 and up)
    (parents' influence important for younger kids)
    (peers influence important for older kids)
- children with disease/predisposing factors
  - -- hereditary risk CVD
  - -- lung disease--asthma, cystic fibrosis
- SES--lower SES at higher risk
- tobacco users; smokeless tobacco as well as cigarettes
  - -- primary prevention--don't start smoking
  - -- smoking cessation

2 problems

- smoking-related medical problems don't manifest themselves in the young (intervene--social arena)
  - -- health care providers can't intervene much in social sphere where intervention may be most effective for youth
- more information needed about effective intervention techniques for youth (either prevention or cessation)

Providers

- physicians
  - -- pediatricians (for well child)
  - -- school physician
  - -- primary care doctors
- school nurse
- specialists in pulmonary and heart disease and respiratory therapist

- dentists and oral hygienists
- nurse practitioners
- physician assistants
- health educators

Type of Intervention

All groups of providers

- medical history--ask about tobacco use:
  -- of self
  -- family
  -- peers

  (note: child might not reveal smoking use; use history-taking as means of reinforcing non-smoking beahvior)
- medical tests for high risk (disease)
- intervention and follow-up for health care providers who interact with kids
  -- raise subject of tobacco use
  -- provide information
  -- reinforce non-smoking behavior

(dentists--same interventions, except lab tests)

- intervene with parents of babies/young children re:
  -- effects of parental smoking on health of children
  -- parents' power as role models

Barriers to Intervention

- no studies of effectiveness of cessation techniques for youth
- no referral resources/no effective cessation programs for youth
- no youth smoking prevention programs geared for doctors to use
- no medical incentive--except prevention
- no recommendation/priority suggested by AMA, NHLBI, etc. ("agenda-setting")
- smoking behavior not on forms for taking medical histories

- lack of time to do intervention
- expert advice--doctors lack confidence about effectiveness/importance of their intervention
- lack of counseling skills (don't know what resources are available)
- trying and being unsuccessful with smoking patients--less likely to try again
- cost of educational materials
- lack of knowledge on how to get reimbursed for counseling
- lack of CME on overcoming intervention barriers--get too much junk mail (information overload)

Responses to Barriers

What do health care providers need to intervene?

- research on effectiveness of intervention techniques/materials
- disseminate information on effectiveness of techniques/materials in highly read journals
- information presented in non-technical terms/formats
- information to motivate physicians to deal with smoking cessation
- develop prevention/cessation programs that doctors can use or refer patients to
- put smoking questions on medical history forms, explore use of computer
- sticker for chart of high-risk patients to remind doctor to ask re. smoking
- develop specific, short, simple intervention protocols

Key actors:

- Ask: American Academy of Pediatrics
  National Association of School Nurses
  American Academy of Family Physicians
  American School Health Association
  American Dental Association
  Other health care provider professional organizations

  to recommend that their members become advocates of non-smoking behavior and provide specific intervention protocol

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- NIH/CDC--technology transfer of research on effective techniques to user community
- produce resource guides, summaries, other materials on effective programs (Office on Smoking and Health, NHLBI, Centers for Disease Control, American Lung Association, American Heart Association)
  -- specific how-to-intervene techniques
  -- include motivation to intervene
- information for health care providers who interact with parents of young children
  -- effects of parental smoking on health of children
  -- parents as role models
  -- advice to quit
- legislative solutions--e.g., raise taxes on cigarettes (clinical organizations recommend this)
- CME--especially when we have more data on effective intervention strategies
- stress role of school nurses (in schools that have them)
- develop community referral resource lists

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SMALL GROUP C

CLINICAL OPPORTUNITY: **Health Care Providers and Institutions as Role Models and Catalysts in Creating Healthy, Smoke-Free Environments**

Definition of Clinical Opportunity

Individual Health Care Providers

- Personal exemplars (at least not negative role model)
  -- but go beyond
  -- take active part as catalyst in change

Hospitals

- No smoking, except in designated areas
  -- accommodate smokers
  -- message: smoking is socially unacceptable
- Smoking cessation clinics
  -- exchange for limits on smoking in hospital
  -- provide a real clinical service--not a PR function
  -- clinical responsibility
- Ask about smoking at all admissions and give information about smoking cessation
- MD must take seriously role in affecting hospital's policies regarding smoking
  -- work in committees
- All providers affect change and transmission of norm to each other and patients

MD Offices

- Easier to accomplish (most waiting rooms already no smoking?)
- intervention model = no smoking + health education messages + asking every patient about smoking + advise and counsel or refer every patient-- personalized intervention
- Environmental changes should be real--"take home with you"

Barriers with Possible Responses Listed Underneath Each Barrier

- MDs may not accept role as exemplar
  -- so at least not be a negative role
- MDs not used to working together as change agents
  -- encourage, help them

- MDs and hospital administration worry about loss of: patients, employees, revenues, gift shop sale of cigarettes
  -- studies show not so

- MDs not comfortable with failures in counseling smoking patients
  -- acknowledge, provide support

- Smoking behavior of policy-makers
  -- don't antagonize their defensiveness

- Unions (e.g., housekeepers, janitors, etc.) object to non-smoking rules
  -- give "health package" in return

- Terminally ill smoking patient
  -- MD can "prescribe" (allow) smoking

- Enforcement
  -- self-policing, social norm

- Long waits in clinics vs. MD waiting rooms
  -- offer alternatives:
    - candy, gum
    - educational opportunities

- Smoking seen as behavioral problem--not realm of MDs
  -- but it is an addictive behavior that constitutes a medical problem
  -- needs to be accepted as a medical problem that we treat with compassion

- Clinical teachers don't teach smoking intervention
  -- be role models as interveners
  -- talk it up

- Political barriers (tobacco industry) in parts of country and business leaders in conglomerates that include tobacco-related business

Intervention Opportunities

- Develop and distribute intervention protocol and examples of achievable results
  -- comparable to how physicians intervene with other diseases in their practices

- Example of protocol's achievable results:

	Patients in a General Practice			
	Start	Reach	Quit	Left
Counseling for all--3 min.	500	500	25 (5%)	475
Counseling--10 min., 2x for all	475	475	50 (10%)	425
Refer to self-help program	425	150	27 (18%)	398
Refer to cessation clinic or in-house extended counseling	398	80+	24 (30%)	374
R_x nicotine gum + 10 min. counseling	374	80	16 (20%)	358
			142 (28%)	

142 quits out of 500 patients = good medicine

How Do We Get This Out?

- Detail men in drug companies to get out protocols (e.g., as way to make nicotine gum effective)
  -- also take materials about smoking cessation programs
- People make little changes better than big ones
  -- couch as easy next step in their practice
- MDs influenced by peers more than medical journals
  -- grass roots approach--county medical society
- Detail men will go to small hospitals to talk to medical staff about nicorette and smoking cessation programs
- American Hospital Association
  -- how do we get to them?
  -- have MD groups/associations write suggesting they endorse no-smoking policies in hospitals (ALA did to JCAH--as part of review)
- Surgeon General's call for a smokeless society by the year 2000
  -- use this to jawbone AHA, VA, military hospitals (especially federal hospitals)
- American Nurses Association, PAs, RRTs
  -- take stand against smoking--not only personal, but in the environment in which they work
  -- national, state, local
- Tests etc. help demonstrate effects of smoking where not conspicuous--inform about risks
- MD training has to be mixed in with regular CME programs
  -- include smoking cessation in program on cardiovascular disease
  -- can run through "our protocol" in limited time period and they can implement
  -- people who are already interested can benefit from this "90 minute" presentation--reaching the reachable
- Movement toward smoke-free areas in hospitals
  -- needs national leadership and grass-roots organizing
  -- use Great American Smokeout Day as catalyst--get American Cancer Society involved in this
- Training issue for all providers
  -- where do you get training to be a smoking cessation leader?
  (1 program/year in Colorado--not well advertised--by ALA)
  -- gear programs specifically to MDs, to PAs, to RNs?
  -- MDs unlikely to attend unless specifically for them
  -- same true re. PAs
- This training has to include some "how to" information (as second course?)

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- Nicotine chewing gum + tests = gets MD involved--makes person feel treated

- Professionals need intervention training for confidence's sake
  -- book helpful, leadership session helpful, but need actual experience--observe counseling personally--via videotape
  -- information about nicotine gum

- Issue of alternatives to mass dissemination
  -- articles in journals
  -- Surgeon General's report re. health care professionals' role in smoking cessation
  -- chapter on hospital policy
  -- chapter on MD offices
  -- chapter on PAs
  -- chapter on RNs
  -- chapter on reimbursement

- Source that says where to get smoking cessation materials (Office on Smoking and Health)

- Need continued support of Smoking and Health Reporter

- Central repository of professional/patient education smoking materials

- Don't have degrees in smoking cessation
  -- need to keep up to date
  -- new materials--good
  -- helps with burnout

- Need for collegiality among smoking cessation educators
  -- a la American Association of Diabetes Health Educators
  -- support could come from Merrill Dow, others
  -- workshops--primary and advanced

- Starting with health workers in hospital--motivated
  -- then go to patients

- Doctors agree that it should be done--then be done by someone else

- Influence national boards to include questions about smoking cessation on boards

- Wellness movement + self-care movement in a lot of hospitals
  -- trade on this--it stimulates smoking intervention activity
  -- is there an association of this?

- Nurses are a well organized group that can be galvanized easily and carry out primary care and coordination roles

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SMALL GROUP D

CLINICAL OPPORTUNITY: High-Risk Patients

Patients Who Have High Receptivity to Message

1) Post-MI

2) Post-bypass

3) Other CHD

4) Chronic Obstructive Pulmonary Disease (COPD)--clearly abnormal function

5) COPD--mild impairment

6) CVA--cerebrovascular accident

7) TIA--transient ischemic attack

8) Cancer of head, neck, lung, GU

9) Repeated upper-respiratory infections

10) Hypertension

11) Hypercholesterolemia

12) Diabetics

13) Peripheral vascular disease

Providers

Post MI: Short-Term (in CCU)

- Primary care physician)
- Cardiologist) primary interveners
- CCU Nurse)

- CV surgeon)
- Respiratory therapist)
- Hospital health educator) secondary interveners
- Hospital cessation programs)
- Clergy)

Intermediate Stage (out of CCU, in hospital)

- Ward nurse
- Primary care physician

- Cardiologist
- Cardiac rehabilitation staff
- Hospital cessation program

Long-Term Stage--out of hospital
- Primary care physician
- Office nurse
- Cessation program--hospital or community

Chronic Obstructive Pulmonary Disease (COPD)
- pulmonologist
- pulmonary technicians
- respiratory therapist

Cancer
- Oncologists
- Dentists
- Oncology nurses

- Radiation therapists

Intervention Strategy

- Relate smoking to individual disease--"personalize" smoking as a problem
- Relate smoking to level of risk of death, worse condition
  -- benefit of stopping--quantify
- Give clear "stop smoking" message
- Provide access to smoking cessation program
  -- deal with cessation problems (weight gain)
- Provide follow-up--bug them over time
- Provide help during maintenance period
- Provide patient with skills--cessation and maintenance
- Provide educational materials

Barriers to Intervention

Information/Knowledge
- Some nurses don't fully acknowledge health risks of smoking
- Nurses fear weight gain if they quit

- Providers don't know that intervention can work (lack information on successful intervention methods)
- Don't know what cessation programs work and for what type of patient
- Physicians don't know how much power they have regarding patient cessation
- Don't know 4-5 relapses common among patients who try to quit (think they're failures if patients relapse)

Motivation/Support

- Role of nurses--not perceived by other providers (sometimes selves) as independent practitioners
  -- lack "permission" to intervene
- Nurses--no rewards for intervening (may cost doctor money)
- Physician role--not defined as smoking intervener
- No role models--leaders in field not reinforcing smoking intervention as "standard" practice
  -- concept of "educational influentials" as role models
- Physicians more interested in disease than prevention or maintenance
  -- smoking not considered disease
  -- preventive medicine--second class citizen
- Fear interveners will be seen as "nudge" and may lose patients/no time to market
- Fear of failure--no peer support when patient relapses
- Smoking intervention not "real doctor" role

Intervention Skills

- Need to know what intervention techniques actually work and how much (treatment protocol)
- Some don't have strong counseling/intervention skills
- Not comfortable as counselors
- Need to practice intervention skills, not just theory

Educational Materials

- Not enough on what intervention works and how much

How to Overcome Barriers

- Increase undergraduate-level curricula that transmit intervention skills
- Support teaching of smoking intervention
- Need CME courses on intervention skills for physicians and nurses (NCI working with Center for Health Education to do pilot on this)
- Help define provider role as including intervention--work with "role-defining" organizations/groups
  -- American College of Deans of Nursing Schools
  -- for nurses--after school, how to reach them (state CME, organizations)
  -- role model teachers--not necessarily dean
  -- specialty professional organizations
  -- AMA
  -- large hospitals that do CME
- Develop educational materials for doctors/others to do health education in local community (serve as intervention role models)
- Articles in professional journals on smoking intervention--especially for nurses
- Need to go beyond just developing and disseminating unsolicited materials to providers
  -- need to use other channels of communication (e.g., CME)
- materials specifically for nurses

Families of Patients with Smoking-Related Disease

- Providers need to do risk factor appraisal for family members
- Contrary to tradition that patients identify themselves
- Turn intervention with family members into physician marketing tool
- How to locate this type of intervention
  -- need hospital labs (stress testing, etc.)
  -- maybe hospitals should contact families
- Have to have programs to meet needs that are identified through this process
- Need research on how physicians deal/don't deal with families now
- Need family screening protocol for kids, siblings of young CHD patients

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SMALL GROUP E

CLINICAL OPPORTUNITY: Regular, Periodic Visits to Physician

Characteristics of Clinical Opportunity

Periodic Visit to Physician: Physician delivers message; another person may do assessment

- History, physican examination
- Lab and screening
- Immunizations
- Counseling, prevention, anticipatory guidance
- Elderly, women
- Specialty exam
  - -- birth control exam
  - -- complete physicals, military, female pap exam
  - -- sports, pre-employment, life insurance, health insurance
- Pathology-induced exam
- Not good pulmonary screening unless occupation is high risk
- 18-55-year-old men avoid exams
- Variation related to access to facility and doctor education

Types

- GYN, pediatrician, internist, family physician, nurses
- Exams are inconsistent (parameters), within and between groups of physicians
- Senior citizen residential community
- Social service contact points

Health Care Providers

- *Family practitioners
- *Internist
- *Pediatrician

- *OB/GYN
- *Nurse
- *Nurse practitioners (often in a clinic setting)
  -- Subspecialties
- School nurse (nurse educator)
- Health educators (hospital/on the job/academic institution)
- Preventive medicine specialist
  -- *Occupational medicine
  -- public health
- Psychotherapist
- Physician assistants (especially *military and *rural)
- Medics
- Osteopathic physicians
- Respiratory therapists
- Visiting nurses or clinic outreach program
- Emergency room staff
- Dentist
- Stress clinics/programs

Types of Interventions

- Identify smoker and history
  -- how much
  -- family pattern
  -- how many times quit before
  -- attitude toward quitting
  -- exercise history
- Pulmonary function tests
- Physical exam
  -- some cases an x-ray
- Take history on other risk factors
  -- blood pressure, cholesterol, weight, heart disease, lung disease, occupation, cancer

- Identify psychosocial factors which enable smoking
  -- why--understand motivation
- Assessment of patient's knowledge, attitudes/beliefs about smoking
- Share (encourage) alternatives for smoking behavior
- Support patient's attempts to change
- If smoking is a hindrance to patient's condition, require smoking cessation
- Profile patient and give back personal information
- Have outreach program for low-income patients

Barriers to Intervention

- Time (caseload doesn't allocate enough time per patient)
- Cost of test
- Staff salaries (time for history and physical; interpret info)
- Could have "free" tests by voluntary organizations which may be resisted by physicians
- Need for assessment instruments
  -- psychosocial factors
  -- family histories
  -- standardization of measures
- Lack of interview skills
  -- probing skills
- Educational level of provider
- Don't know effective methods and what to do on follow-up
- Lack of incentive (whether intervention works)
- Lack of knowledge for referrals
  -- quality and effectiveness of cessation programs
- Lack of feedback to physicians on whether intervention works (lack of positive response)
- Lack/unable to work in a team (sub-specialty areas)
- Feeling among elderly that smoking cessation won't help (too late)
  -- health care professionals may also hold back from intervening

- Lack of motivation on part of patient influences doctor, nurse, etc., to not intervene
- With low-income patient--lack of time, etc., magnified in emergency setting
- Lack of government support with low-income to encourage smoking cessation or prevention
- Lack of or need for hard data on cost benefits

What is Needed to Overcome Barriers

- Develop overall/comprehensive plan
  -- define roles of health care providers
  -- define strategies
  -- determine cost
- Develop package (paper and pencil or computerized profile) which defines:
  -- type of info needed) done before physician sees patient
  -- tests which are useful)
  -- physician role--delivers intervention message
  -- adjunct person's role
  -- info on referrals
  -- follow-up system from referral--feedback to physician and health care professional
- Training for health care providers on:
  -- interviewing skills
  -- information needed
- Need more data on side-stream smoke effects
- Use physician as catalyst to give message--let others gather information for assessment
  -- have questionnaire/checklist
- Develop audiovisual tape on health education and tests available to play in emergency room, well-baby clinic (instead of soap operas)
- Community education like hypertension program
- Take an inventory of existing health outreach programs and have smoking included
  -- use volunteer groups like Red Cross, AHA
- Need to get results from evaluations of smoking cessation programs being done now by NHLBI, NCI (literature review of these programs)
- Get data on proprietary programs--e.g., Smokenders (have they been evaluated?)
- Get physician organizations to support/encourage physician smoking cessation efforts through CME credits, establishing status image, requirements for fellow status

- Through education, develop attitude that prevention is "care-giving," is "practicing medicine"
  -- educate that it is "changeable"; smoking cessation efforts work
- Get board exams to include smoking cessation information questions
- Get third-party reimbursement for smoking cessation efforts
- Encourage education on smoking as a risk factor to focus on the psychosocial dynamics of smoking; interactive effect with other behaviors; and physicians' role as interveners
- For resistant patients:
  -- don't put on defensive
  -- physicians provide information verbally
  -- provide written information
  -- how hard to push depends on patient benefits

How Do We Reach Health Care Providers?

- Filter information from top down

-- undergraduate education	) written materials) textbook
-- graduate education	) video/audio material
-- postgraduate education	) courses with live trainers) self-contained training module

- Disseminate through professional organizations:
  -- physician associations/nursing associations/P.A. associations
  Council on Health Education within associations
- Disseminate through self-help groups developed for cancer, heart disease, etc.
  -- Candlelighters, Mended Heart
- Government Task Force recommendations (U.S. Task Force on Preventive Services) to third party payors; Congress
- Develop and disseminate health videos to hospitals and hospital satellite networks (health care education) and PBS
- Give public info through media so patients will ask physician/health care providers for services (pamphlets, PSAs, TV programs)
- Raise price of cigarettes as deterrent--and/or tax cigarettes to provide for research, education programs

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Key Groups to be Involved

- Federal government--Public Health
  - -- NHLBI
  - -- Office of Disease Prevention and Health Promotion
  - -- Centers for Disease Control
  - -- National Cancer Institute
- AMA and other physician associations
- nursing associations
- American Hospital Association
- Hospital corporations for profit
- HMOs
- other hospital organizations (i.e., Voluntary Hosp. of America)
- military organizations
- American Association of Retired Persons
- people from tobacco companies
- Ad Council or other media groups
- airlines
- Voluntary organizations
  - -- American Heart Association
  - -- American Dental Association
  - -- PTA (parents)
  - -- American Cancer Society
  - -- teacher organizations
  - -- etc.

APPENDIX D

PRE-WORKSHOP "FOCUS PAPER"

SECTION I:

INTRODUCTION

The National Heart, Lung, and Blood Institute (NHLBI) is congressionally mandated to develop and foster information and educational activities designed to reduce preventable heart, lung and blood disease morbidity and mortality. Within the Institute, lead responsibility for initiating educational activities is located in the Office of Prevention, Education and Control (OPEC). NHLBI demonstration and education activities are targeted at a diverse audience of health care providers, public health practitioners, the general public, and specific subpopulations.

One of the most successful health education programs conducted by NHLBI is the National High Blood Pressure Education Program (NHBPEP). Created in 1972, NHBPEP represents a focused effort to increase public and professional awareness of high blood pressure. Under the leadership of the Institute, the joint national effort includes numerous federal agencies, virtually all state health departments, and more than 150 private-sector organizations such as professional societies, voluntary health associations, certifying and accrediting bodies, pharmaceutical companies, labor and management groups, and insurance companies. As a model program, NHBPEP reflects the benefits of a collaborative effort joining a wide variety of organizations and agencies in a cooperative effort to reduce a major public health threat.

In addition to its ongoing educational activities focusing on high blood pressure, NHLBI is currently planning two national health education initiatives: 1) the National Cholesterol Education Program, and 2) the NHLBI Smoking Education Program. Each planning effort will generate recommendations to NHLBI about the specific program elements which should be included in each health education program and the overall strategy by which the program should be structured and implemented.

NHLBI has selected two target categories of health education in which to develop its smoking program approaches and activities: 1) professional and patient education, 2) worksite education. This focus paper addresses issues involved in the development of program approaches and activities for professional and patient education.

NHLBI is committed to providing its leadership and resources in working toward the development of a comprehensive program to strengthen the role of health care providers in cholesterol education. It is also committed to working collaboratively and in a coordinated way with a large number of other federal, state, professional and voluntary organizations who are already involved in and experienced in the smoking field and/or in educating health professionals. To this end, Polaris Research and Development--the contractor working with OPEC staff--has contacted more than 40 agencies and organizations currently involved in health education. Discussions were held with each agency or organization about their current involvement in smoking education efforts, current gaps in health education activities focusing on smoking, and their suggestions about how NHLBI could be more actively involved in smoking education. Information regarding professional and patient education gathered during the agency and organization contacts is summarized in this focus paper.

The second aspect of NHLBI's collaborative planning effort is a planning workshop on professional and patient education to be held in Silver Spring, Maryland, on January 29-30, 1985. NHLBI is inviting representatives from interested organizations to participate in a two-day workshop. The purpose of the workshop is to involve a group of knowledgeable professionals in a collaborative planning process to assist in defining an overall program profile to strengthen the role of health care providers in smoking intervention and in defining specific program elements and strategies for NHLBI health education efforts in coordination and collaboration with other organizations.

SECTION 2:

BACKGROUND

Smoking as a Health Risk

Health statistics indicate that smoking causes even more cardiovascular death than tobacco-related death by cancer. In 1980, cardiovascular disease accounted for approximately half of all U.S. deaths, or more than 960,000 deaths. Coronary heart disease (CHD) alone is estimated to have accounted for about 550,000 deaths. Of these deaths from CHD, it has been estimated that 30%, or more, could be attributed to cigarette smoking; this estimate means that approximately 170,000 Americans die prematurely of CHD each year as compared with an estimate of 129,000 premature cancer deaths annually attributable to cigarette smoking. Smokers also experience increased death rates due to other cardiovascular diseases in addition to CHD, such as stroke, peripheral vascular disease, and other vascular problems.

The three major risk factors for coronary heart disease are smoking, hypertension and elevated blood cholesterol. The 1983 Report of the Surgeon General concluded that cigarette smoking should be considered the most important known modifiable risk factor for coronary heart disease in the United States. Overall, smokers have a 70% greater CHD mortality than non-smokers. Heavy smokers--those who consume more than two packs a day--experience CHD mortality rates almost 200% higher than non-smokers. There is significant evidence that while cigarette smoking is a major independent risk factor for CHD, it may also act synergistically with other risk factors (most notably, elevated blood cholesterol and hypertension) to greatly increase the risk of CHD. The data suggest that cigarette smoking interacts with the other two major risk factors to produce a combined risk that is greater than the sum of the risk that would have been produced by the same risk factors acting separately. (1)

Smoking is also the major cause of chronic obstructive lung disease (COLD), particularly chronic bronchitis and emphysema. Over 60,000 deaths occur in the U.S. as a result of COLD. Estimates indicate that 80-90% of these deaths are the result of cigarette smoking. COLD is the fastest-rising cause of death in this country. (3) Morbidity statistics are even more alarming. Over 10 million Americans experience debilitating effects of chronic bronchitis and emphysema. A further indicator of the impact of COLD

is the amount of medical attention people receive. In 1978, for example, COLD was the cause of approximately 9.8 million office visits and 2.4 million patient days. (2)

Smoking Cessation

Substantial progress has been made in changing the smoking habits of Americans, and this appears to have contributed to the significant improvement in mortality rates from cardiovascular diseases. Declines in cigarette smoking rates among adults were first noted in 1964, the year of the first Surgeon General's Report. More than 30 million smokers have quit since 1964, and the proportion of adult smokers has declined from over 40% of the population in 1965 to approximately one-third today. (1)

While the most effective way to avoid the negative health effects of smoking is to have never smoked, prospective mortality studies have determined that cessation of smoking results in substantial reduction in CHD death rates compared with those of persons who continue to smoke. Mortality from CHD declines rapidly after cessation. Approximately ten years following cessation, the CHD death rate for those ex-smokers who consumed less than a pack of cigarettes daily is virtually identical to that of life-long non-smokers. For ex-smokers who had smoked more than one pack per day, the residual risk of CHD mortality is proportional to the total lifetime exposure to cigarette smoke. (1) A recent study indicates that even among older persons who have smoked for decades, the effects of smoking with regard to CHD mortality are at least partially reversible within 1-5 years after quitting. (8)

In terms of COLD, cessation of smoking has a substantial impact on the incidence and progression of COLD. Cigarette smokers who quit before developing abnormal lung function are unlikely to go on to develop ventilatory limitation. If cessation occurs after substantial lung damage has developed, the impact is a slowing of the rate of decline in lung function with age. After a period of cessation, this rate of decline in function may approximate the rate found in nonsmokers, but there is little evidence to suggest that those who quit are able to regain their prior excess functional decline. Therefore, those who quit continue to have reduced lung function when compared with those who have never smoked, but their lung function begins to decline less rapidly with age when compared to the lung function of those who continue to smoke. (3)

Although virtually all Americans know that smoking causes health problems, and although there have been declines in cigarette smoking prevalence among American adults, there

continue to be an estimated 55 million smokers in this country smoking an average of 21.7 cigarettes per day. This continued prevalence of smoking places great emphasis on the need to identify and implement intervention strategies which will result in further changes in cigarette smoking behavior.

In preparation for the first NHLBI smoking education planning workshop, a review of the literature on smoking intervention strategies involving health care professionals and their effectiveness was conducted. The following is a brief summary of that review. First, the results of a number of large-scale clinical trials are discussed. Then the results of studies focusing specifically on physician roles and their effectiveness in smoking intervention are summarized. Very few studies have been conducted or reported on regarding the roles of other health care professionals in smoking intervention and thus the information discussed here is limited to physicians.

Smoking Intervention Strategies

A number of large-scale primary prevention trials have been undertaken in an attempt to test the effect of the modification of major risk factors, either alone or in combination, on coronary heart disease or respiratory disease. While a major problem in assessing outcomes of smoking intervention studies has been that the research has often been inadequate in methodology, quality control and/or design, several of these trials have provided an opportunity to assess the efficacy and outcomes of their smoking intervention techniques within certain significant limitations.

The 1983 Report of the Surgeon General summarizes four clinical investigations* in which individuals were randomized either to an intervention group or to their usual source of medical care, and in which there were long-term follow-ups of at least three years. (1) The reported cessation rates for the intervention groups in these trials range from 29% to 40% at three years. The best outcome was attained by the most intensive and perhaps the most extensive approach of the Multiple Risk Factor Intervention Trial (MRFIT). Each of the trials provided some continued contact for the intervention-group smokers during the first two years of the trials. The London Civil Servants Smoking Trial included a substudy where some intervention participants received the usual procedure of further contact by personal consultations, and another subgroup received further contact by mailed personal responses from the physician. A comparison of these intervention subgroups found that

*The London Civil Servants Smoking Trial, the Goteborg (Sweden) Primary Prevention Trial, the Oslo (Norway) Study, the Multiple Risk Factor Intervention Trial (MRFIT)

the smoking cessation outcome was significantly poorer when the personal contact was omitted.

In a comparison of community trials, where entire communities were randomized to an intervention or non-intervention group, the Surgeon General's Report notes that in general, the use of community programs that used only a media approach did not produce a greater intervention effect than was observed in the comparison community. The incorporation of more intensive personalized intervention in addition to the media approach was necessary before significant differences could be realized. The World Health Organization European Collaborative Trials involved trials carried out at four centers: the United Kingdom, Belgium, Italy and Poland. In each trial, factories or other occupational facilities were matched and then randomly allocated to an intervention or a control group. Screened participants in the intervention groups received general information on risk factors and mass media intervention. In addition, high-risk smokers received more intensive intervention through individual examinations and counseling. There were significant differences in the reported cessation rates for high-risk smokers who received intensive intervention as compared with smokers in the control factories.

Overall, the Surgeon General's Report concluded that smokers involved in intervention programs demonstrate higher smoking cessation rates than those in control groups, and, in general, the success of smoking intervention programs is related to the amount of intervention provided.

A number of studies have focused specifically on the role of the physician as an intervener in his or her patients' smoking behavior. Such intervention strategies cite the physician/patient relationship as providing an important opportunity for realizing long-term behavior change. (3) The recent Cancer Prevention Awareness Survey conducted by NCI found that over 90% of the respondents said they were likely or very likely to follow their physician's advice concerning ways to reduce their chances of getting cancer. (4) These results are similar to earlier surveys where the majority of persons felt that physician advice to quit or cut down on smoking would be influential. (3)

A number of recent studies have found that very high proportions of physicians routinely ask their patients about their smoking behavior. In a survey of primary care practitioners in Massachusetts, 90% who responded said they routinely asked about smoking. (3) In a survey of Maryland physicians, 72% said they always gather information on smoking, and

92% said they regularly or always gathered such information. (5) In a survey of pulmonary clinicians, over 95% responded that they determined their patients' smoking habits. (9)

While high rates of interviewing and gathering information on patients' smoking practices are reported, it appears that rates of counseling on smoking behavior change are somewhat lower. In a survey of members of a county medical society in California, 70% of the respondents reported that they knew how to interview their smoking patients, but only 21% reported that they knew how to counsel them. (10) In the survey of Massachusetts primary care practitioners, only 58% felt "very prepared" to counsel patients, and in the Maryland survey only 35% felt "very prepared" to counsel patients in smoking cessation and reduction. And in each of these studies, only a small percentage of responding physicians reported that they were currently "very successful" in helping patients change their smoking behavior (3% in Massachusetts, 4% in Maryland and 12% in the county medical society).

While it appears that an increasingly high proportion of physicians are interviewing their patients concerning smoking, the lower rates of actual counseling appear to be reflected in the patient reports on incidents of physicians advising them to quit smoking. A number of studies have found that only 25-30% of current smokers report receiving physician advice to quit. (3)

While physicians may offer and patients may hear varying degrees of smoking cessation counseling, there are a number of studies which have assessed the effectiveness of physicians as interveners and have provided some indication of the comparative effectiveness of various intervention strategies.

In reviewing studies of physician effectiveness with patients' smoking behavior, it is important to differentiate between 1) primary care physicians who relate primarily to general practice patients, including smoking patients not experiencing smoking-related problems, and 2) physicians in specialties concerned with pulmonary and cardiovascular diseases who relate to smoking patients experiencing, first-hand, the health problems resulting from continued smoking.

Nine principal studies have dealt specifically with general practice patients. (3) Analysis of individual study findings and particularly cross-study analyses are difficult given differences and/or weaknesses in methodology, in definitions (e.g, "cessation" including

significant reduction in smoking, elimination of cigarette smoking or elimination of all tobacco consumption), and lack of control groups in some studies. Recognizing these limitations, the studies have generally found increased cessation rates with physician intervention as opposed to no intervention. Further, most studies found increases in cessation rates when physician advice was accompanied by additional techniques including distribution of pamphlets and/or warnings of subsequent follow-ups.

For example, in a large-scale English study, Russell et al. assessed the effectiveness of physician smoking advice as compared with no advice. Four groups of patients were used: a non-intervention control, a questionnaire-only control, an advice-only group, and an advice group receiving a two-page pamphlet and a warning of subsequent follow-up. The percentages of patients who stopped within one month of the initial visit and who were still abstinent at the one-year follow-up were 0.3%, 1.6%, 3.3%, and 5.1%, respectively. These results indicated that personal, direct advice to quit, although brief, was effective and enhanced by written material and information about a subsequent follow-up.

A number of other studies have also suggested that a simple follow-up procedure may enhance the effects of physician advice. For example, in a Canadian study by Wilson et al., 211 smokers received brief (3-5 minute) intensive counseling to quit smoking and a pamphlet. Subsequently the participants were randomly assigned to one of two groups. One group was given follow-up appointments at one, three, and six months to review and discuss problems, while the control group received follow-up appointments as needed for complaints but no further smoking cessation counseling. The group receiving follow-up appointments and counseling reported a 23% cessation rate at 16-14 months as compared with a 12% rate in the control group.

Studies which have investigated smoking cessation among patients with respiratory disease and cardiac disease tend to indicate that the presence of serious illness increases cessation compliance rates among patients. (3) Eleven studies investigating quit rates among pulmonary disease patients following physicians' advice have found compliance rates varying from 15-51%, though none of these studies included no-advice control groups. Cessation rates found in studies among cardiac patients have ranged from 22-94%, with the majority of studies falling in the 40-60% range.

As with general practice patients, interventions with patients experiencing smoking-related diseases have generally been most effective when intense intervention strategies

are used. As discussed above, in the large London Civil Servants Smoking Trial, 1,445 men at high risk for cardiorespiratory disease were randomized into an intense intervention group and to a normal care group. At three years, 36% of the intervention subjects and 14% of the control subjects were not smoking cigarettes.

In a test of the effect of intense advice on post-myocardial infarction cessation, Burt et al. assigned patients to intense or to routine advice conditions. Intense intervention consisted of telling the patient repeatedly in the coronary care unit, during convalescence and during follow-up that he should never smoke again in his life, plus giving him a pamphlet. Abstinence rates among those receiving intense advice were 62% as compared with 27.5% for those receiving routine advice at the time of a three-year follow-up.

The literature also indicates, however, that patients with major smoking-related problems continue to smoke at a significant rate. In the Coronary Artery Surgery Study (CASS), 780 patients with stable ischemic heart disease were randomly assigned to medical or surgical treatment to assess the comparative effects of these two therapies on quantity and quality of life. At the time of entry, the percent of cigarette smokers in both groups was comparable (41% and 39% respectively). The percentage of patients who smoked fell slightly one year after randomization in both groups (to about 32%), but it did not change significantly thereafter. Further, recent studies examining quit rates among pulmonary and post-MI patient groups indicate a general trend toward a decrease in success over time, with more recent studies reporting lower rates. The literature reports that this apparent decline in effectiveness may be because physicians specializing in pulmonary or cardiac disease are left to deal with the more recalcitrant, hard-core smokers.

The literature discusses the fact that some physicians can become discouraged in their cessation education efforts, particularly those with general practice patients where their rate of success may be 5%. (3) The potential effectiveness of ongoing physician motivation and reinforcement has been indicated in several studies. Ewart et al. examined physician success rates as a function of the time since participation in a CME training program. All physicians were shown to become less effective as time passed over a nine-month period. In a study involving a small family planning clinic, the effectiveness of maintaining physician performance by a feedback intervention was demonstrated. When the percentage of patients reporting advice declined, a private communication was made with the physician. After each feedback session, the physicians involved in the study increased the percentage of patients counseled to quit smoking.

The most valuable types of assistance in their smoking intervention efforts identified by physicians have varied among studies. One study cited information and referral sources, financial reimbursement for health promotion services and staffing, literature for distribution to patients, and training for physicans, support staff or both. (3) The Maryland survey concurred that information on where to refer patients was the most valuable type of assistance needed, also citing the need for literature for distribution to patients, physician education in behavior modification, and physician education in specific health promotion subjects. (5)

With regard to patient literature, some participants in the focus groups conducted as part of the Maryland study felt that plenty of publications were already available. Others suggested that the pamphlets should be shorter and simpler. Most participants indicated that they received an enormous amount of mail and were selective in what they read. A number remarked that they read only the respected and prestigious medical journals and were less likely to read unsolicited items unless they clearly came from the medical society or the National Cancer Institute. The most useful items mentioned by a majority of the participants were courses, literature and other forms of education that would specifically enhance their ability as health care providers. Here again, participants emphasized the importance of the program being offered by or endorsed by organized medicine or another recognized entity, e.g., the medical society or a national institute.

In summary, the literature suggests that physicians can plan an effective role in smoking cessation. Clearly, health care providers can and must respond by increasing their efforts in smoking cessation and prevention. And equally clearly, there are critical ongoing and expanding roles to be played by federal and state agencies and by voluntary organizations and professional associations in strengthening the ability of health care providers in these efforts. Among these roles are continued research efforts by the National Institutes of Health (particularly NHLBI and NCI) to identify effective smoking intervention strategies involving health care professionals. As this research proceeds, NHLBI is also committed to making its contribution to the network of organizations currently involved in smoking education. The next section of this paper summarizes the current smoking education activities of other federal, voluntary, professional and community organizations as background to considering appropriate role and program strategies for NHLBI's involvement.

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SECTION 3:

SUMMARY OF EXISTING SMOKING EDUCATION ACTIVITIES

Introduction

The release of the first Surgeon General's Report on smoking in 1964 triggered a rapid initiation of smoking education activities. Both the number of organizations involved and the level of their activity increased throughout the 1970s and into the 1980s. Major roles have been played by such federal agencies as the Office on Smoking and Health, the Centers for Disease Control, and the National Cancer Institute, and such major national voluntary organizations as the American Cancer Society, the American Heart Association, the American Lung Association and the American Medical Association. In addition, there are numerous national, state and local professional, community, private and educational organizations active in health education efforts directed at cessation and/or prevention of smoking.

A principal objective of the current NHLBI smoking education planning process is that it be a collaborative effort between NHLBI and other federal agencies, state agencies and voluntary, professional, community, business and industry, and private and educational organizations which have previously been involved in smoking education efforts. As part of the planning process, contacts have been made with over 40 agencies and organizations involved in smoking education. Through these contacts, information has been gathered about the agencies' and organizations' past, current and projected future roles in smoking education, and copies of any materials developed by them have been gathered. A review of the existing range of activities and materials concerning professional and patient smoking education is provided here, with some specific examples cited. This review discusses physician/patient education activities first and then activities involving other health care providers and patients.

Physician and Patient Health Education

There are a variety of points in the education and practice experience of physicians at which information, training and materials may be provided to support their efforts in patient smoking education and intervention. For example, physicians can receive smoking prevention and cessation education as medical school undergraduates, during their postgraduate education, through continuing medical education courses, through

information provided to them for use in their clinical practice, through information provided to assist them in referring smoking patients to other health care providers or cessation programs, and through information provided to assist physicians to become involved in community education.

The following summary describes some of the major existing physician and patient smoking education intervention approaches and materials which have been undertaken by the most active agencies and organizations. It is organized in terms of these "opportunities" to affect and enhance physicians' smoking intervention efforts as part of their education and practice experience.

- **Undergraduate education.** According to the professional medical organizations which were contacted during the interview process, little has been done at the undergraduate level to educate physicians about smoking in general or the need for physician intervention with smoking patients in particular. Several organizations mentioned that physicians currently receive little training about smoking as a major risk factor. None knew of any undergraduate curriculum which focused on intervention techniques. Typically, the emphasis of undergraduate medical school education is on disease. Although "disease prevention" is a growing interest, most professional organizations characterized it as still being a "low priority" at the undergraduate level.

- **Postgraduate education.** Even at the postgraduate level, little is being done to educate physicians about smoking and to train them to become more effective interveners with their smoking patients. At the graduate level, cardiologists receive training on risk factors, but there is little organized teaching about the importance of smoking cessation as a way of reducing the risk of CHD. One organization attempting to fill this gap is the American Academy of Family Physicians (AAFP). The basic goal of the American Academy of Family Physicians is to work to maintain and improve high standards of family practice. Family practice residency requires that residents participate in a community education program by presenting at least one health education protocol to organizations or businesses in their community. AAFP is developing nine protocols or modules, each of which will include three separate presentations of one-half hour each. Among the nine protocols to be developed will be one on "Smoking and How to Break the Habit." This will provide not only a community service but an important training opportunity for family practice residents.

- **Continuing medical education.** Continuing medical education courses offer an important opportunity for smoking education, but little has been done in the area of smoking cessation intervention. One organization active in exploring continuing medical education in the smoking field is the American College of Cardiology. The College offers 70-80 CME programs per year which are attended by more than 6,000 physicians. Although it does not currently have a continuing medical education course specifically on smoking and the need for intervention, the Preventive Cardiovascular Disease Committee of the College is currently involved in exploring the need for a smoking-specific CME topic.

  Another organization attempting to fill the gap is the Center for Health Education, Inc. The Center is a joint venture of the Medical Chirurgical Faculty of the State of Maryland and Blue Cross and Blue Shield of Maryland. Committed to the belief that health education is a process that helps people adopt healthy lifestyles and adhere to medical advice, the Center believes that physicians are the single most credible source of health information for most people and are therefore in a unique position to promote and bring about changes in lifestyle and habits. To enhance the physician's role as a health educator, the Center has undertaken a range of activities including the provision of training sessions for physicians to improve their communication skills and to develop techniques promoting wellness among their patients. It has developed a series of one-day workshops for physicians on the barriers to physician/patient communication and has conducted a survey of over 1,700 office-based physicians in Maryland on the role of physicians in health promotion. The Center is now exploring the role of the physician in cancer risk reduction with the support of the National Cancer Institute. It is examining the needs of physicians in this area and developing plans for a cancer risk reduction education program for physicians, which would include smoking education.

- **Educational materials designed for use in the clinical practice.** By far the greatest number of smoking educational program approaches and materials have been developed for use by physicians in their clinical practices, and within this area the majority of the materials developed tend to be written "kits" or other educational materials developed to assist the physician in intervening with smoking patients. Among the most widely distributed of these materials are:

  -- The National Heart, Lung, and Blood Institute has developed a physicians guide to smoking intervention for physicians who have hypertensive patients.

Entitled "How to Help Your Hypertensive Patients Stop Smoking," the 24-page guide was developed by a working group of physicians, behavioral psychologists, and health educators. The guide describes an approach called the "Minimal Smoking Cessation Procedure" because a physician can readily fit the approach into every routine office visit with high blood pressure patients. The guide also includes an "Expanded Smoking Cessation Procedure," which offers several more detailed approaches to helping hypertensive patients quit smoking.

-- The Office of Cancer Communications of the National Cancer Institute has recently combined and revised two smoking cessation kits formerly provided separately to physicians and dentists. The new version is designed to assist both physicians and dentists in counseling their patients on ways to quit smoking and consists of two patient booklets ("Quit It," an aid to quitting smoking, and "For Good," an aid to maintaining non-smoking behavior), a guide for the physician ("How to Help Your Smokers Become Non-Smokers"), and waiting room materials consisting of posters and tent cards.

-- The American Heart Association has developed a physician kit entitled "Calling it Quits." The kit includes two patient booklets ("How to Quit," a guide to helping the patient stop smoking, and "The Good Life," a guide to becoming a non-smoker), a guide for physicians ("How to Help Your Smokers Quit") and several posters targeting specific patient populations (e.g., pregnant women, black families). The AHA materials were developed in consultation with NCI, and there are areas of similarity in content and format between the kits of the two organizations. AHA is initiating a year-long field test of the "Calling it Quits" kit. AHA is targeting internists and cardiologists for dissemination of its materials.

-- The American Cancer Society has developed a physician "Help Quit Kit." The kit consists of an instructional folder which provides physicians with practical instructions about how to intervene with smoking patients, desk-top and wall versions of smoking warning signs, posters for use by general practitioners, pediatric specialists, and OB/GYN physicians, a "Prescription Pad" containing a preprinted smoking message, and two patient brochures entitled "Quit Smoking Now: Before You Have to Quit," which includes tips on quitting, and "Quit Smoking Now: The Lives You Save Could Be Theirs," which describes the risk to family members. ACS also attempts to address physicians through a wide variety of professional education publications--typically reprints from

their own journal or from other medical journals. These publications, which typically range from 10-50 pages, are distributed to approximately 470,000 physicians across the country. ACS is also currently developing a major initiative in the area of prevention which is expected to target smoking as well as nutrition, sunlight, etc. As part of that initiative, ACS is developing a new slide or videotape presentation on smoking for physicians and other health care professionals. It will also develop ads for medical journals and work to involve health care professionals more actively in its annual Great American Smoke-Out.

-- The American Lung Association is currently working with NHLBI to develop a new physician smoking intervention kit with information on how to counsel patients, respond to their questions and make referrals to ongoing sources of smoking cessation support. ALA has also developed a "self-help" kit for patients who wish to stop smoking entitled "Freedom from Smoking." ALA has also developed and distributed a kit to professionals directed at smoking cessation among pregnant women. This is a "how-to" guide which includes materials for use by the pregnant woman.

-- The American College of Chest Physicians has had a smoking cessation program targeted at chest physicians for almost 15 years. The program stresses that the chest physician 1) has a responsibility as a role model to stop smoking or not to smoke in front of his or her patients, and 2) is responsible for assisting patients to stop smoking. The program includes participation in a one-day workshop which is designed to instruct the physician on how to teach his/her patients not to smoke. The physician receives a smoking cessation work kit. It includes information on the relationship of cigarette smoking to emphysema, lung cancer and cardiovascular diseases. It also includes information which can be given to the patient: one handout addresses questions smokers commonly ask; another describes techniques for working with the patient on smoking cessation. Physicians also receive posters for their offices.

- **Referral to other smoking cessation programs.** In some cases, physicians with smoking patients may want to refer them to formal smoking cessation programs. Since there are a host of programs available and few physicians or patients are familiar with them, the New York Heart Association developed a pamphlet entitled "Stub it and Stop it: A Guide to Smoking Cessation Programs." The

pamphlet describes the effect of cigarette smoking on the heart and includes basic questions and answers about cessation. The majority of the pamphlet describes the range of cessation strategies (e.g., self-care/self-control, individual counseling, group counseling, behavior modification, hypnosis, medication and drugs) and indicates special risk factors associated with different methods of smoking cessation. It also provides information about how smokers can go about finding a cessation program which is appropriate for them.

- **Community education materials.** The Office on Smoking and Health is currently revising a slide show on smoking for physicians or other health care professionals to use in community education forums. The revised slide show is projected to be completed by spring 1985. It will include 20-25 slides and a script for a half-hour presentation which can be made by physicians or other health care providers to lay audiences. The slide show focuses on the medical and social implications of smoking and describes the health effects and prevalence of smoking as the nation's major preventable health problem. OSH also encourages health care organizations which make use of the slide show to add additional slides on their area of specialty concern (e.g., pregnant women, patients with heart disease).

Other Health Care Providers and Patient Smoking Education

Although physicians are the target for most smoking health education materials, several other health care providers have also been targeted. As with physicians, the majority of the materials are directed at practicing providers. Major examples include:

- **Pharmacists.** The NCI Office of Cancer Communication in cooperation with the American Pharmaceutical Association has developed and pilot-tested a smoking cessation kit for pharmacists. The kit focuses on the potential interference of smoking with the effectiveness of medications and prescription drugs, and includes a pamphlet ("Clearing the Air"), a "Calendar" noting three things to do during the first 30 days that a person is trying to quit smoking, a guide for the pharmacist ("Helping Smokers Quit") and posters and tent cards ("If You Really Want to Quit, a Pharmacist Can Show You the Way").

- Nurses. The new prevention initiative being planned by the American Cancer Society will give special emphasis to nurses. Nurses will receive attention not only because they are health care providers but because of the high rate of

smoking among nurses. ACS plans to develop professional education articles and posters for nurses and ads will be placed in nursing journals. The message to nurses will be to act as exemplars of non-smoking behavior and to intervene with patients who smoke. At its annual conference this year, the American Nurses Association passed a resolution on smoking issues which specifically encourages ANA members to recognize the intensity of the smoking problem. The resolution further states that ANA will 1) support activities directed toward reducing smoking among nurses, 2) identify funding sources and encourage nurses to be participants in smoking behavior research, 3) formulate policies and use political power to influence policy-makers toward smoking control efforts, and 4) assist nurses in increasing their awareness that smoking is a major threat to the health of all individuals.

SECTION 4:

PLANNING ISSUES

Issues Raised During the Interview Process

In addition to a review of the literature and a review of existing activities and materials related to professional and patient smoking health education, the planning process for NHLBI's health education program has included contacts with representatives of NHLBI, other federal agencies, voluntary organizations and professional organizations to solicit their ideas and suggestions concerning priority issues to be addressed in the area of professional and patient anti-smoking education.

In their comments, the organizational representatives contacted addressed three major issues:

- Can physicians and other health care providers be effective interveners with patients who smoke?
- What constraints keep physicians and other providers from intervening more effectively with their patients who smoke?
- How can physicians and other providers become more effective interveners with their patients who smoke?

Can Physicians and Other Health Care Providers Be Effective Interveners with Patients Who Smoke?

A number of professional organizations cited the enormous "agenda-setting power" which physicians have vis-a-vis their patients. They indicated that physicians and other health care providers who make it their business to intervene actively with their smoking patients can have an enormous effect. They suggested that many health care providers simply don't believe that they can be effective interveners and that this misconception needs to be refuted. One suggested that "we need to work with physicians so that they better understand their power in setting a treatment agenda for their patients. We need to get them to understand that they won't win all the time, but that they can have a real positive impact on many smoking patients."

What Constraints Keep Physicians and Other Providers from Intervening More Effectively with their Patients Who Smoke?

Many professional organizations described a number of significant environmental constraints which limit physicians' and other health care providers' abilities to intervene effectively with their patients who smoke. Several organizations mentioned that doctors and other providers currently receive little training about smoking as a major risk factor in general and intervention techniques in particular. At the undergraduate and graduate levels of physician and nursing education, the emphasis is on disease; curricula seldom focus in great detail on risk factors or disease prevention and almost never contain educational components on smoking cessation intervention skills. Continuing education programs, which are important vehicles for reaching physicians, nurses, pharmacists and other health care providers, are offering few programs on smoking prevention and cessation intervention.

As a result, few physicians and other health care providers have the needed skills to intervene successfully with their smoking patients. As one professional organization put it: "Physicians are well trained to treat an illness, but they haven't been trained to intervene with smokers. They need to know how to intervene and they need confidence that they can make a difference." Several organizations suggested that providers lack "confidence" in their intervention skills and that they need to be able to both learn and practice them in a "non-threatening" setting.

Another constraint to health care providers' involvement identified by those contacted is that providers typically do not receive reimbursement for cessation counseling activities. In other cases, the problem involves constraints associated with "practice management." Few physicians have an effective system for identifying and tracking patients who smoke. Record-keeping within physician offices often does not make it easy for physicians to keep track of smoking patients who have been encouraged to quit.

Another major constraint cited by professional organizations is that physicians and other health care providers who do attempt to intervene with smoking patients are often demoralized by their limited success. Several representatives indicated that many physicians feel that when a smoking patient attempts to quit and has a relapse, it represents a "failure." One organization suggested that it is common for smokers to attempt to quit smoking 4-5 times before they are ultimately successful, and that

physicians and other providers need to learn that and become more patient and realistic in their expectations.

How Can Physicians and Other Providers Become More Effective Interveners with Their Patients Who Smoke?

In discussing the need to motivate physicians and other providers to intervene with their smoking patients, a number of respondents identified several factors which will increase the likelihood of effective intervention. They include:

- **Leadership.** A number of organizations indicated that part of the problem is physician "role definition." They indicated that what is needed is for recognized opinion leaders (e.g., the National Institutes of Health, leading physicians within specialty areas) to say clearly and unequivocally that physician intervention with smoking patients is "real medicine." People and institutions that physicians look to for guidance and for a definition of their roles as physicians should make it clear that smoking intervention is a duty of physicians--that it is an essential part of the total practice of medicine. It was suggested that the approach should be to stress that "smoking intervention and patient counseling is the natural thing to do as part of the overall medical care provided to patients--it's the physician's responsibility to get involved in this."

- **Intervention skills.** The need to provide physicians and other health care professionals with effective intervention skills and materials and the confidence to use those skills and materials was identified by most organizations. Several representatives indicated that the transmittal of intervention skills is not that difficult, but needs to be done in a more focused way. One suggested that "we can give physicians enough intervention skills in about eight hours of training." Several suggested that continuing education courses on smoking intervention should be developed and made available to physicians and other providers. One suggested that provider training should be "specific, hands-on training." It should be "light on theory and spend more time on role-playing counseling techniques" to help providers become confident of their skills. Despite identifying the need for continuing medical education which focuses on smoking cessation techniques in specific, several professional organizations were unsure whether physicians would be attracted to attend those training sessions. Several reiterated the need to "clearly define smoking cessation intervention as an integral part of the

practice of medicine" as a way to build interest in continuing medical education on intervention techniques.

- **Support.** Most organizations that are interested in encouraging physicians to become more involved in smoking cessation efforts indicated that the "message" about the link between smoking and CHD and other diseases is clear and that what is needed is to "induce providers to deliver the message." Several suggested that doctors need to see that they are getting a "return" from their intervention efforts, such as being paid for their efforts or receiving approval and status from their peers for becoming effective interveners. The need for peer support was mentioned by several individuals and organizations who cited the discouragement that physicians often feel when they are unable to convince a smoking patient to stop or when a patient who has stopped smoking has a relapse.

Consensus on the Need

There appears to be a consensus that there is a need to strengthen the contribution that health care providers make to eliminating the largest single preventable cause of illness and premature death in the United States--smoking. The effectiveness of health care providers can be enhanced by ensuring that they:

- are knowledgeable about the full impact of smoking on their patients' health, including the fact that smoking is a major cause of and the most important modifiable risk factor for CHD and COLD;
- are fully aware of the magnitude of health benefit outcomes which are realized through smoking cessation;
- are aware of the power to influence healthful behavior that exists through the provider/patient relationship and through specific clinical opportunities;
- are encouraged to identify clinical opportunities for smoking education intervention;
- recognize and accept a responsibility as health care providers: 1) to prescribe smoking cessation as part of their treatment efforts with patients experiencing smoking-related problems, and 2) to promote, as part of their concern for disease prevention and health promotion, smoking cessation among patients not yet experiencing smoking-related problems;

- are knowledgeable about and have intervention skills and educational materials which will assist them and their patients in realizing smoking cessation;
- are encouraged and reinforced on an ongoing basis to actively carry out their roles in smoking intervention.

The comments and suggestions of representatives of a wide range of organizations indicate that the primary emphasis must be placed on **motivating** physicians and other health care providers in this role, on providing them with the **skills and resources** to carry out their role, and on providing them with **ongoing support** and **encouragement** in these difficult efforts.

A comprehensive program to so strengthen the health care provider role would itself involve intervention with a broad spectrum of health care providers and through a wide range of points of intervention with them. To fully realize the role which can be carried out by health care providers, the importance of smoking intervention must be introduced, emphasized and reinforced throughout the professional education and clinical practice of health care providers.

Issues to be Addressed at the NHLBI Workshop

The purpose of the NHLBI workshop is to determine where priority efforts to meet this need to strengthen the role of health care providers in smoking cessation should be placed and what specific program elements and strategies should be pursued by NHLBI in collaboration and coordination with other organizations. It is suggested that the workshop focus on:

1) identifying clinical opportunities that exist in the practice of health care where smoking intervention techniques can be employed, and which are not currently being fully capitalized on, toward:
   -- prevention of tobacco-related diseases, and
   -- the control of diagnosed disease (both tobacco-related and non-tobacco related);
2) identifying which health care providers and what program elements and strategies need to be targeted in order to strengthen the ability of health care providers to capitalize on these high priority clinical opportunities:

-- Should major efforts be placed in affecting the undergraduate and/or postgraduate education of targeted health professionals so they are more motivated and more equipped to capitalize on the priority clinical opportunities? If so, what knowledge and competency areas should be emphasized in new formalized curricula for which health care providers?

-- Do new provider/patient education programs and supportive materials need to be developed and provided to targeted health care providers in order to ensure they have the resources to capitalize on the priority clinical opportunities? If so, what patient needs should be addressed? What techniques for behavior change recommended?

-- Do these health care providers need skill development more than or in addition to new materials? If so, what would be the most effective strategies for providing this skill development, e.g., continuing education programs?

-- Is there a major need to develop support strategies which will build and maintain the motivation and commitment of health care providers to the difficult charge of intervening in patients' smoking behavior?

And in response to each of these issues, what are the most appropriate initial specific program elements and strategies for NHLBI to pursue, in coordination and collaboration with other organizations, as it builds its involvement in strengthening the role of health care providers in smoking intervention?

APPENDIX E

PLANNING WORKSHOP PARTICIPANTS

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PLANNING WORKSHOP FOR PROFESSIONAL AND PATIENT EDUCATION
JANUARY 29-30, 1985

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